Arizona Medical Board

9545 East Doubletree Ranch Road • Scottsdale, Arizona 85258
Home Page: http://www.azmd.gov
Telephone (480) 551-2700 • Fax (480) 551-2704 • In-State Toll Free (877) 255-2212

FINAL MINUTES FOR REGULAR SESSION MEETING
Held at 9:30 a.m. on August 10, 2005, and 8:00 a.m. on August 11, 2005
9535 E. Doubletree Ranch Road · Scottsdale, Arizona

Board Members

Tim B. Hunter, M.D., Chair
William R. Martin III, M.D., Vice Chair
Douglas D. Lee, M.D., Secretary
Patrick N. Connell, M.D.
Ronnie R. Cox, Ph.D.
Robert P. Goldfarb, M.D.
Ingrid E. Haas, M.D.
Becky Jordan
Ram R. Krishna, M.D.
Lorraine L. Mackstaller, M.D.
Sharon B. Megdal, Ph.D.
Dona Pardo, Ph.D., R.N.

WEDNESDAY, August 10, 2005

CALL TO ORDER
Tim B. Hunter, M.D., Chair, called the meeting to order at 9:30 a.m.

ROLL CALL
The following Board Members were present: Tim B. Hunter, M.D., William R. Martin III, M.D., Douglas D. Lee, M.D., Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Becky Jordan, Ram R. Krishna, M.D., Dona Pardo, Ph.D., R.N. Ronnie R. Cox, Ph.D., Ingrid E. Haas, M.D. and Lorraine L. Mackstaller, M.D. The following Board Member was not present: Sharon B. Megdal, Ph.D.

CALL TO THE PUBLIC
Statements issued during the Call to the Public appear beneath the case referenced.

Sharon B. Megdal, M.D. joined the meeting at 9:36 a.m.

The Call to the Public was concluded at 9:52 a.m.

Executive Director's Report

Timothy C. Miller, J.D. informed the Board that he submitted the Executive Director's Report for their review and that Board approval was required before he submitted the Annual Report and Strategic Plan.

Sharon B. Megdal, Ph.D. discussed the Human Resources Report and asked if every person who departs from the agency is given an opportunity for an exit interview. Timothy C. Miller, J.D. stated that this was the current policy. Dr. Megdal asked Mr. Miller to verify that everyone had received the opportunity and if not, they should be given an opportunity for an exit interview. Mr. Miller agreed to do that. Dr. Megdal stated that Mr. Miller did not need to report back on the issue.

Dr. Megdal then discussed the Annual Report and noted that the letter of submission appeared to be too detailed and seemed to be more of an administration report rather than a transmittal report submitted to an annual report. Dr. Megdal felt it was unusual to include technical problems in a transmittal letter to governor and stated that it came across negatively and she was not comfortable with that. Ram R. Krishna, M.D. agreed. Mr. Miller agreed to revise the letter of submission before submitting the Annual Report to the Governor.

MOTION: Ram R. Krishna, M.D. moved to approve the Annual Report and Strategic Report with minor changes to the submittal letter.
SECONDED: Patrick K. Connell, M.D.
VOTE; 11-0 yay, 0-nay, 0-abstained/recused, 1-absent
MOTION PASSED.

Legal Advisor Report

Christine Cassetta, Assistant Attorney General submitted supplemental information to the Board regarding editing the Board minutes from the May 18, 2005 meeting. The Board chose to leave the minutes as originally approved.

MOTION: William R. Martin III, M.D., moved to leave the minutes as originally approved.
SECONDED: Ingrid E. Haas, M.D.
VOTE: 11-yay, 0-nay, 0-abstained/recused, 1-absent
MOTION PASSED.

Off-Site Meeting Agenda

The board discussed agenda items for the Off-site meeting on September 9, 2005.

Tim B. Hunter, M.D. suggested adding an item to discuss: 1) Developing guidelines for the communication process between the board and staff through email and, 2) How to determine when the information becomes public.

Sharon B. Megdal, Ph.D. suggested adding an item to review the investigation and SIRC processes. Dr. Megdal also suggested adding an item to discuss guidelines for when to deliver press related information to the Board

Dr. Lee suggested adding an item to discuss the selection process for the Medical Consultant in the investigation process.

Dr. Hunter requested that the agenda not be too specific so that the Board would have more latitude in its discussions.

2006 Meeting Dates

The Board discussed the proposed 2006 meeting dates. Staff proposed changing the April 2006 meeting date to accommodate a religious holiday. The Board agreed to the 2006 meeting dates as amended.

Proposed Office Based Surgery Rules

William R. Martin III, M.D. informed the Board that the Office Based Surgery Committee has completed its draft rules and provided the Board with a general overview of the rule content. Dr. Martin also invited Larry Lanier from the American Association of Dermatologists and Stacy Gaus from the Association of Nurse Anesthetists to speak to the Board about their comments regarding the proposed office-based surgery rules.

Mr. Lanier thanked the Board for the opportunity to speak about the proposed rules. He informed the Board that his association represents dermatologists who often perform office-based minor surgeries under minimum sedation. Mr. Lanier informed the Board that he is very happy with first draft rules presented today. He commended the Office Based Surgery Committee for their hard work and their commitment to patient safety in Arizona. Mr. Lanier also stated that he understands that there may be future modifications to the rules and he will continue to work with the Committee as those changes are implemented. Finally, Mr. Lanier thanked the Committee and Board staff for their courtesy and willingness to include public comments during the rule drafting process.

Stacey Gaus also spoke to the Board regarding the proposed rules. She too stated her appreciation with the responsiveness of the Committee and their willingness to allow outside parties to provide feedback. While she appreciates the content of the proposed rules, Ms. Gaus stated that her association had some concerns regarding the rigidity of some of the rule language. Ms. Gaus added that she is confident that a compromise can be found that will satisfy all parties during future rule reviews.

Ram R. Krishna, M.D. stated that he appreciated the stakeholders coming from Washington, D.C. to take part in the public comment process. He stated that he realized that the rules had been put on the backburner due to changes in the Committee membership and in Board staff, but that Dr. Martin and Dr. Lee, as well as the Executive Director, were instrumental in bringing the issue back to the Board's attention. Tim B. Hunter, M.D. commended the Committee for its hard work and stated that the proposed rules were put together well. This is an issue that many hospitals are currently dealing with and the rules dovetail into current national standards.

Dr. Martin stated that following Board approval of the draft office-based surgery rules a docket would be opened with the Secretary of State's Office and the document would again be opened for public comment. Dr. Martin added that he would like this portion of the process to be completed by December 1, 2005.

Sharon B. Megdal, Ph.D. stated that she also appreciates seeing stakeholders at meeting. She stated that while it seems as though there are still some issues to work out, she is confident they will be worked out amicably. Dr. Martin added that stakeholders were contacted early in the research process and many of their comments were incorporated into the draft rules presented to the Board. He understands the concerns with the rigidity of some of the language, and that the language is required by the Governor's Regulatory Review Counsel (GRRC) and the Board might not be able to change it.

Robert P. Goldfarb, M.D. asked if the Board would see the rules again before there is a final published version. Mr. Miller informed the Board that the rules will go back through the Committee and will return to the Board for final approval before the final version is published.

MOTION: Patrick N. Connell, M.D. moved to accept the Office-Based Surgery rules as drafted.
SECOND: Robert P. Goldfarb, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

Dr. Martin took a brief moment to thank the Committee. He stated that Dr. Krishna and Dr. Lee did most the work and need to be commended. Additionally, the rules would not have reached this point without the support of Board staff. Dr. Martin thanked Mr. Miller, Ms. Cassetta, Ms. McGrane, Ms. Dana and Ms. Parrish for their hard work.

Scheduled Discussion of Executive Director's First Six Months – Performance Review

MOTION: Tim B. Hunter, M.D. moved to go into Executive Session.
SECONDED: Patrick N. Connell, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED

The Board returned to open session at 3:36.

Tim B. Hunter, M.D. stated that overall, the Board is happy with the direction Mr. Miller is taking the agency. The Board feels there is a lot of work that still needs to be done and the Board wants to exert their effort to help Board staff continue in the direction Mr. Miller is taking them. The Board is looking forward to progress and looking forward to future meetings to discuss process improvement. Board members concurred.

Approval of Minutes

MOTION: Becky Jordan moved to approve the June 8-10, 2005 Executive Session Minutes
SECONDED: Ram R. Krishna, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED

Dona Pardo, Ph.D., R.N. provided Board staff with minor corrections to the June 27, 2005 meeting minutes.

MOTION: Douglas D. Lee, M.D. moved to approve the July 27, 2005 Summary Action Meeting Minutes
SECONDED: Ram R. Krishna, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED

MOTION: Dona Pardo, Ph.D., R.N. moved to approve the July 6, 2005 Teleconference Minutes
SECONDED: William R. Martin, III, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED

Adopt Substantive Policy Statement – Medical Doctor Fees

Christine Cassetta, Board Legal Advisor explained that in 2001 the Board was presented with proposed increased physician fees. The 2001 meeting minutes reflect the Board approved the proposed fees in their entirety, but Staff recollection is that the Board did not approve all of the increases. For reasons currently unknown, the Board's Rules were not edited to reflect all of the fee increases. This caused some confusion during a recent financial audit requested by the Executive Director. Ms. Cassetta asked the Board to adopt a substantive policy statement to reflect the increase in all fees as apparently approved in 2001 until the rule addressing the Board's fees could be amended. Mr. Miller added that staff is looking for clear direction about which fees the Board intended to increase.

Tim B. Hunter, M.D. tabled this agenda item for a later date.

ADVISORY LETTERS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-03-0595A	G.F.	DANIEL E. LINK, M.D.	20963	Dismissed.

This case was pulled for discussion. Robert P. Goldfarb, M.D. questioned why this case was recommended for an advisory letter. The facts in the case support dismissal because the doctor closed his practice in 2002 when he went to work for the prison system and notified his patients of the office closure. The complainant requested his records a year later, but Dr. Link was unable to provide them.

MOTION: Robert P. Goldfarb, M.D. moved to dismiss this case.
SECONDED: Ingrid E. Hass
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent

MOTION PASSED

2.	MD-04-0459A	AMB	THOMAS J. GRADE, M.D.	10424	Continue the investigation and invite the physician for a formal interview.

Dr. Thomas Grade spoke at the Call to the Public. Dr. Grade is a Board certified pain specialist and anesthesiologist. Dr. Grade has other board certifications as well. Dr. Grade stated the initial complaint was inappropriate and alleged he excessively prescribed opiates. The patient, A.H., is a male in his 40's who suffers from neuropathic pain in the hand and feet from diabetes. Dr. Grade performed surgery on him and placed electrodes in his spine. Dr. Grade prescribed methadone and limits his maximum does to 240 mg per day.

Dr. Grade placed the patient on a Fentanyl patch. The patient was accused of diverting one Fentanyl patch. There is no evidence of addiction. His urinary testing was negative for THC and was positive for OAC. This was an issue of stolen identity and the case was dropped. Dr. Grade stated that the pharmacist in this case acted inappropriately and in order to lodge a case against the pharmacy Dr. Grade needs a dismissal letter. As a result of this case, Dr. Grade's medical group has segregated and the patient was dismissed from the practice without his consent.

Robert P. Goldfarb, M.D. pulled this case for further discussion. Dr. Goldfarb's concern was that the case might need to go to a formal interview. He was not comfortable with the case after reviewing the three paragraphs of the Medical Consultant's supplemental report and in listening to the testimony of Dr. Grade during the Call to the Public.

Sharon B. Megdal, Ph.D. stated that Dr. Grade mentioned in the Call to the Public another complaint was filed by a different pharmacy chain. There are also four existing complaints against this physician. Dr. Megdal questioned if there is a larger case than the one before the Board.

William R. Martin III, M.D., stated that after reading the physician's profile it appeared as if his residency was not finished. Dr. Grade made comments that he was board certified by a number of boards. This is usually not consistent when a residency has not been completed. It is not required to finish a residency in order to implant devices surgically, but it would seem inadvisable to do so. Ms. Cassetta said residents apply for license while they are in residency, and the subsequent completion date may never be reported to the Board, but it doesn't necessarily mean it was not completed.

MOTION: Robert P. Goldfarb, M.D. moved to continue the investigation and combine other cases if appropriate, and invite the doctor in for a formal interview.
SECONDED: Lorraine Mackstaller, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED

3.	MD-04-1422A	C.S.	CHARLES E. ECHOLS, JR., M.D.	5022	Dismissed.

William R. Martin, III, M.D. stated that he knows the physician, but that it will not interfere with his ability to adjudicate the case.

Robert P. Goldfarb felt the doctor did the right thing by notifying the Board of his change in practice. The doctor mailed letters to his patients that had been in his practice for over two years. The records were available at the Barrow Neurological Institute. There was some follow-up when someone wrote in, but he felt the doctor did the right thing.

Brenda Heverly, Senior Medical Investigator, stated that Dr. Echols was retired and had been employed by Barrow Neurological Institute. Ms. Heverly contacted the patient and asked when the patient requested the medical records. The request was made after the doctor retired.

MOTION: Robert P. Goldfarb, M.D. moved to dismiss the case.
SECONDED: Ram R. Krishna, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED

William R. Martin III, M.D. stated that during the offsite meeting, the Board should discuss the process where an investigator can come forth if he or she disagrees with the Staff Investigational Review Committee (SIRC) recommendation. That way, cases like this do not have to come before the Board. If it weren't for Dr. Goldfarb asking to discuss this case the doctor may have received an advisory letter.

Timothy B. Miller, J.D., Executive Director, informed the Board that there are a number of complaints regarding records issues such as this one. While some cases can be dismissed, often times the physician's failure to respond to a record request in a timely manner can be critical to the patient. In this case, SIRC took into account the facts surrounding the case and recommended an advisory letter. The Board agreed that this discussion should be deferred to another agenda.

4.	MD-03-0785A	AMB	CHARLES M. CREASMAN, M.D.	13814	Issue Advisory Letter for failure to document the patient's post-operative status.

William R. Martin, III, M.D. stated that he knows the physician, but that it will not interfere with his ability to adjudicate the case.

5.	MD-04-0855A	J.H.	ROBERT A. MILLER, M.D.	25824	Dismissed.

Robert A. Miller, M.D. spoke at the Call to the Public. Dr. Miller stated that he has evaluated numerous cavity lesions and has performed over thousand biopsies for cavity lesions. This was the most challenging case Dr. Miller had ever experienced. The patient had chronic tongue biting and irritation. It is well documented in the records by numerous physicians. Over the course of five years one biopsy was performed and three complete excursions of disease tissue. Somewhere along the line it turned into a malignancy. Every decision that was made was reasonable. The Medical Consultant recommended this case be dismissed. There was an additional medical consultant review and that also recommended this case be dismissed. Dr. Carlson expressed concerns with tongue palpitations. Dr. Miller did palpitate the patient's tongue and his records reflect this. As chief resident he was responsible for teaching residents, and he always taught them how to palpitate a tongue when there is a lesion. Dr. Miller's current practice is to always palpitate when lesions are present. His March 26, 2003 notes indicate the patient's tongue is scarred and fibrosed. The only way to determine that a tongue is fibrosed is by feeling it. After four procedures of biting and rubbing his tongue within seven years there is scarring on the tongue. A fifth biopsy cannot be done unless the scar tissue is removed from the entire area. When Dr. Miller noticed the situation he recommended the patient get an opinion from another physician before proceeding to a fifth biopsy. Diagnosing cancer in this setting is extremely difficult to do. This patient did not have any of the conditions listed under a traditional textbook case. After reviewing the medical data, he could not find one occurrence of chronic tongue biting turning into cancer. This is the only case he has ever seen.

The Board pulled this case for discussion. Based on the comments in the Call to the Public, Sharon B. Megdal, Ph.D. was convinced this should be dismissed.

Ram R. Krishna, M.D. stated there was a missed lesion and it was potential harm. Dr. Megdal said Dr. Miller did palpate the tongue. She questioned if the advisory letter was for failure to palpate or failure to diagnose a malignant lesion. The doctor also talked about how unusual this lesion was.

Robert P. Goldfarb, M.D. asked Mark Nanney, M.D., Chief Medical Consultant, for his opinion in this case. Dr. Nanney stated Dr. Miller's last exam was in June when he noted the patient had pain and bleeding and the lesion markedly was worse. Dr. Rothman performed a second opinion exam on July 28th that showed speech dramatically altered, the tongue was frozen in position, there was a deep laceration, bleeding, and so he did a biopsy and found a malignancy. Dr. Nanney wondered why Dr. Miller wasn't alarmed when he saw this patient in June. Dr. Miller also stated similar findings and felt there was nothing else they could do, and he let the patient go. The outside medical consultant also had concerns about Dr. Miller's charting over the two-year period leading up to that. The outside medical consultant was particular concerned about palpitation.

Tim B. Hunter, M.D. felt the doctor did what he could and asked what more could he have done.

Dr. Krishna asked if the lesion was aggressive enough to change in two months. Dr. Nanney was not sure.

Dr. Megdal noted the literature referred to tobacco patients getting this type of cancer and stated that rarely does this type of cancer arise in people who have never smoked. Dr. Megdal asked again was it a failure to palpate or diagnose the condition.

Dr. Nanney said the Medical Consultant felt Dr. Miller should take the advice and learn from it. The doctor said it was documented as fibrosis. Dr. Megdal asked if the doctor has to use "palpate" In his records. His wording did refer to the fact that he palpates. She felt the doctor's statement was convincing.

MOTION: Sharon B. Megdal, Ph.D. moved to dismiss the case.
SECONDED: William R. Martin III, M.D.

Moving forward, Dr. Nanney stated that he would follow the Board's direction to interpret these statements from the outside medical consultant's, but would keep in mind the practices of the Board. Dr. Megdal felt the role of the outside medical consultant is to provide a recommendation to the Board. The medical consultant would then put the recommendation into the action that needs to be taken.

Dr. Goldfarb felt Dr. Nanney, as Chief Medical Consultant should not filter the outside medical consultant's report. In this case, the outside medical consultant's recommendation was filtered and he did not recommend an advisory letter. Dr. Hunter agreed that the outside medical consultant's report should not be filtered, but added that the Board's medical consultant should be allowed to state his opinion if it differs.

Dr. Nanney noted that the outside medical consultant recommended dismissal, but that he had found a number of deficits. When Dr. Nanney questioned him about the deficits, the outside medical consultant agreed that the deficits were below the standard of care.

VOTE: 11-yay, 1-nay, 0-abstain/recuse, 0-absent (Ronnie R. Cox, Ph.D. opposed)
MOTION PASSED

6.	MD-04-0749A	W.F.	STEPHEN E. HANKS, M.D.	31740	Issue Advisory Letter for diagnosing severe spinal stenosis and recommending surgery without supporting clinical and radiological data. While there is insufficient evidence to support disciplinary action, the Board believes that continuation of the activities that led to the investigation may result in further Board action against the licensee.

Tim B. Hunter, M.D. recused himself from this case.

Lorraine Mackstaller, M.D. stated that Dr. Hanks has taken some of her patients, but she does not know him personally and it would not influence her ability to adjudicate this case.

This case was pulled for discussion. Robert P. Goldfarb, M.D. stated that Steven E. Hanks is a spinal orthopedic surgeon who recommended surgery to a patient for severe lumbar spinal stenosis when that diagnosis was not present. This indicates Dr. Hanks either misread the MRI scan or there is some type of pattern here because Dr. Hanks is an orthopedic surgeon and the patient really had a hip problem. It is not unusual for someone to present with spinal stenosis when the patient has degenerative hip disease. The neurosurgeon made the diagnosis of hip disease. Dr. Goldfarb was not concerned that he missed the diagnosis, but was concerned that he was willing to operate on this patient for spinal stenosis without looking at the films.

There were discussions on whether the doctor read the wrong patient's x-ray. It was determined after the discussions that there was no evidence to prove that he read the wrong MRI. Ms. Cassetta stated the records reflect the patient, in correspondence to the Board stated, "She couldn't believe he was reading her MRI," Ms. Cassetta noted perhaps SIRC misinterpreted that statement as an allegation rather than the patient stating her disbelief when told the diagnosis.

Dr. Krishna stated that sometimes patients say they have a hip problem when it is actually sciatic pain. He may have looked at the x-ray and felt that it was from the sciatic nerve.

Dr. Goldfarb asked if this should be an advisory letter or he should be invited for a formal interview. Ms. Cassetta stated there is potential harm to consider.

MOTION: Robert P. Goldfarb, M.D. moved to issue an advisory letter for diagnosing severe spinal stenosis and recommending surgery without supporting clinical and radiological data. While there is insufficient evidence to support disciplinary action, the Board believes that continuation of the activities that led to the investigation may result in further Board action against the licensee.
SECONDED: Patrick K. Connell, M.D.
VOTE: 11-yay, 0-nay, 1-abstain/recuse, 0-absent
MOTION PASSED

7.	MD-04-0853A	C.W.	DAVID L. CHILD, M.D.	6275	Issue Advisory Letter for failure to provide informed consent pertaining to anal laser therapy and for failure to inform the patient during post-operative discussion that the anal laser therapy was performed. This violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.
8.	MD-04-0969A	AMB	NEWTON A.F. SAMPAIO, M.D.	10975	Issue Advisory Letter for failure to obtain an independent review of a pigmented lesion, specifically, independently reviewing both specimens side-by-side. The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.
9.	MD-03-0450A	AMB	RANDI GERMAINE, M.D.	21309	Continue the investigation.
14.	MD-05-0158A	R.S.	MARTIN LEHMAN, M.D.	18680	Continue the investigation.

Mark Nanney, M.D. presented a brief overview of these two cases. Randy Germaine, M.D. and Martin Lehman, M.D. prescribed drugs for their spouses and did not try to conceal this. They both felt that this was harmless. They didn't write excessive quantities and did not try to divert drugs. They had both listed appropriate indications for the drugs. They simply made a mistake.

Becky Jordan was concerned about consistency. It seems as though in the past the Board has normally reprimanded physicians who commit these types of violations with an action stronger than an advisory letter. The Board members provided a number of examples of past cases similar to this one in which they issued either an advisory letter or a Letter of Reprimand depending on aggravating or mitigating circumstances and whether or not there was drug diversion. The Board agreed that ignorance of the law was not an excuse.

Tim B. Hunter, M.D. said in the past the Board has been stricter than this. The Board wants to get the message out that this is something you cannot do. A lot of physicians do not realize it and it is still a problem. Dr. Hunter would like to continue these investigations and research the Board's past decisions and maintain consistency. Ms. Cassetta noted her recollection that prior cases where the Board took disciplinary action in cases where physicians prescribed to their spouses' involved diversion of the prescribed medications by the physician. Ms. Cassetta agreed to research past Board actions in cases similar to this one and bring this information back to the Board.

MOTION: William R. Martin, III, M.D. moved to continue the investigations for both cases #9 and #14.
SECONDED: Sharon B. Megdal, Ph.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED

10.	MD-04-1520A	AMB	DONALD R. SCHIEVE, M.D.	18602	Issue Advisory Letter for failure to record an intraocular pressure. The violation is a minor violation that is not of sufficient merit to warrant discipline.

Ingrid E. Haas, M.D. pulled this case for discussion because the physician had a past action taken by the Board based on similar issues and is currently under a practice restriction. He has been compliant with the terms of his order, but he has poor record keeping. Ram R. Krishna, M.D. stated that this was a one-time occurrence and it does not rise to a disciplinary action.

MOTION: Ingrid E. Haas, M.D. moved to issue an advisory letter for failure to record an intraocular pressure. The violation is a minor violation that is not of sufficient merit to warrant discipline.
SECONDED: Ram R. Krishna, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED

11.	MD-04-1119A	AMB	MICHAEL KASSENBROCK, M.D.	17245	Issue Advisory Letter for failure to report a DUI arrest within the 10-day reporting requirement.

William R. Martin, III, M.D. stated that he knows the physician, but that it will not interfere with his ability to adjudicate the case.

12.	MD-04-1450A	D.H.	JANICE M. LABRANCHE, M.D.	28362	Issue Advisory Letter for failure to respond to patient phone calls regarding adverse reactions to medication and failure to transfer patient records in a timely manner. This is a one-time occurrence not rising to the level of discipline.
13.	MD-04-1199A	AMB	IRA UNGAR, M.D.	10403	Issue Advisory Letter for prescribing Reglan for six months contributing to the patient's tardive dyskinesia. This is a one-time occurrence that does not rise to the level of discipline.

Susan McLellan, counsel for Ira Ungar, M.D., spoke on behalf of Dr. Ungar at the Call to the Public. She said this case was in regards to improper prescribing of Reglan. Ms. McLellan asked the Board to review and dismiss this case. The recommendation was based on false information. Dr. Ungar was not an emergency room physician at the time he prescribed Reglan. Dr. Ungar was employed by Sunnyview Medical Center and he saw this patient as a primary care physician. The original medical consultant report accurately reflects the information and was originally recommended for dismissal. The Chief Medical Consultant report conflicts with earlier reports and does not accurately reflect Dr. Unger's role as a primary care physician at the time he prescribed Reglan. The SIRC report is also incorrect and mimics the first medical consultant report.

The Board pulled this case for discussion. Sharon B. Megdal, Ph.D. noted that the Chief Medical Consultant stated the length of time for the prescription was inappropriate for an emergency room physician, but would be appropriate for a primary care physician. The attorney indicated this was a primary care physician. Dr. Lee stated the recommendation for Reglan is three months or less. Six months is a long time and is outside of the Physician Desk Reference (PDR) recommendation. Dr. Goldfarb said that a patient could develop complications from Reglan and if so, the complications can be serious and irreversible.

MOTION: Ram R. Krishna, M.D. moved to issue an Advisory Letter for prescribing Reglan for six months contributing to the patient's tardive dyskinesia. This is a one-time occurrence that does not rise to the level of discipline.
SECONDED: Patrick K. Connell, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED

15.	MD-04-0155A	E.B.	STEPHEN GLACY, M.D.	17082	Issue Advisory Letter for failure to timely release a patient's medical records. This is a one-time occurrence and does not rise to the level of discipline.
16.	MD-04-0103B	A.C.	RICHARD WHITMAN, M.D.	14188	Dismissed.

William Wolf, M.D., Board Medical Consultant, gave a presentation to the Board. The patient in this case underwent an unnecessary laparoscopy for presumed cholecystitis and choleliathisis. Initially, Dr. Wolf thought Dr. Whitman fell below the standard of care. After reviewing the case it was not possible to prove the computed tomography (CT) scan or the emergency room physician report was on the chart. Dr. Whitman claims those reports were not on the chart at the time the surgery began. In reading the emergency room physician's report it suggests the CT scan was ordered after his discussion with Dr. Whitman. Dr. Wolf felt that neither of the allegations could be supported. It was not possible to prove that Dr. Whitman had any reason to know that a CT scan had been performed. Dr. Wolf recommended this be dismissed. SIRC recommended an advisory letter.

Ram R. Krishna, M.D. asked Dr. Wolf what information the surgeon relies upon prior to surgery. Dr. Wolf specified that he would rely upon the CT scan and the patient's history. Based on the history and the CT scan the procedure would have been entirely appropriate.

Tim B. Hunter, M.D. said there was nothing in the emergency room history or the physical exam that indicates the patient had prior surgery. There were no comments by the emergency room physician or the surgeon about scars on the abdomen. If she did have surgery previously there must have been small scars that healed nicely. Dr. Hunter felt the case should be dismissed.

MOTION: Ram R. Krishna, M.D. moved to dismiss the case.
SECONDED: Patrick K. Connell, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED

17.	MD-04-0907A	J.D.	JAMES GADD, M.D.	8696	Issue Advisory Letter for failure to maintain adequate medical records.
18.	MD-04-1543A	C.C.	L. LOTHAIRE BLUTHE, M.D.	10921	Issue Advisory Letter for failure to perform and document a post-operative slit lamp exam.

Cynthia Kirkland, attorney for Dr. Bluthe, spoke at the Call to the Public. Dr. Bluthe is unable to attend due to a full schedule. Dr. Bluthe is well respected in the community. He has practiced as an ophthalmologist since 1981. On May 1, 2003 patient C.C. came to Dr. Bluthe. C.C. had seen another doctor a day before visiting Dr. Bluthe for a cataract extraction. C.C. complained he could not see unless he had his glasses on. Dr. Bluthe spent 10-15 minutes explaining why he might still be nearsighted. The allegations against Dr. Bluthe were that he had failed to document all the mistakes that had been made and that he had failed to supervise the staff. The medical consultant found Dr. Bluthe did not hide any mistakes and that Dr. Bluthe forgot to document the slip lamp examination. Dr. Bluthe did perform the slip lamp examination and did not document it this time because of the circumstances, which were to determine why the patient was still nearsighted. The medical consultant found there was no patient harm. C.C. returned the next day to get the lens exchange to correct the nearsightedness. Ms. Kirkland requested the board dismiss the case.

19.	MD-04-1529A	CA	IFRAN MIRZA, M.D.	28306	Issue Advisory Letter for failure to appropriately evaluate and document the need for a pacemaker.

Irfan Mirza, M.D. spoke at the Call to the Public. Dr. Mirza stated that he saw the patient on April 4, 2003. The patient's primary care physician referred the patient to Dr. Mirza. Dr. Mirza did see the patient and found the patient was unable to respond and was getting dizzy. Dr. Mirza discussed the option of a pacemaker with the patient. The patient was very receptive for a pacemaker because his primary care physician was telling him since 2003 that he would need a pacemaker. The patient wanted Dr. Mirza to perform the procedure but Dr. Mirza did not have privileges at the hospital locally. Dr. Mirza introduced the patient to another doctor and referred him for the surgery. Dr. Jacobson did perform the surgery with consent from the patient for a pacemaker in the hospital. He left the hospital and received a call received from the nurses that the patient was unstable. Dr. Jacobson returned to see check on the patient.

Dr. Mirza stated that the patient complained about Dr. Jacobson to the State of California. In retrospect, the pacemaker was pacing his heart at least 70% of the time. He was relieved of dizziness. There were no neurological symptoms that could be detected. Dr. Mirza stated that he is the only cardiologist in the city and he has saved over two thousand lives per year. He did about ten to eleven angioplasties last night and still drove here to explain himself even after working from 5:00 a.m. to midnight last night.

MOTION: Ram R. Krishna, M.D moved to issue advisory letters for cases 1-19, with the exception of cases 1, 2, 3, 5, 6, 9, 10, 13, 14, and 16.
SECONDED: Lorraine Mackstaller, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED

APPEAL OF ED DISMISSALS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-04-0904B	S.H.	CARL G. HOFFMAN, M.D.	13316	Uphold ED Dismissal

S.H. spoke at the Call to the Public. S.H. stated she is the grandmother to K.W. She stated that she is not the one who decided to take any action for this case, but wants the Board to know why she appealed the case. The information given to the Board by Dr. Hoffman in relation to a medical procedure he had performed on her grandson and his input regarding who performed the procedure is not true. S.H. is confused as to why Dr. Hoffman told the Board that he had not inserted the PICC line. The original complaint was not against Dr. Hoffman, but against the doctor in the other case. Her grandson is a quadriplegic who survived through 52 days at Chandler Regional Hospital. S.H. stated her life was put at a standstill before Dr. Hoffman had even been in the picture. She could not leave her grandson's bedside because of the severeness of the MERSA from the PICC line and because of the fear that something else would go wrong. She watched him deteriorate from 140 to 92 pounds because of his traumatized bowel. He drove himself to rehabilitation everyday, but was still able to keep his spirits up. Another physician who treated S.H. was shocked at what happened to S.H. Dr. Hoffman's recollection of the events that occurred that day are very different to what she witnessed in regards to the insertion of the PICC line and her grandson being infected with MERSA.

2.	MD-04-1122A	D.D.	THOMAS H. SCHIMKE, M.D.	18080	Uphold ED Dismissal
3.	MD-04-0237A	C.S.	EDWARD J. DOHRING, M.D.	21817	Uphold ED Dismissal
4.	MD-03-1036A	J.S.	TERRANCE P. ADKINS, M.D.	24013	Uphold ED Dismissal

Ed Gaines, attorney for Terrance P. Adkins, M.D., partner with Chandler & Udall LLP, was present for the Call to the Public. Mr. Gaines appeared on behalf of Dr. Adkins who is a board certified colon rectal surgeon. Mr. Gaines stated the Executive Director had dismissed this case on two previous occasions and he urged the Board not to place the case on the agenda if the patient appeals again. The patient saw Dr. Adkins in 2002 and 2003 and Dr. Adkins performed surgery for a suspected anal vaginal fistula on August 11, 2003. Mr. Gaines stated that nothing has changed since the last appeal. The patient is unhappy and the doctor did not get optimal results. It is not malpractice or unprofessional conduct. Many of the patient's complaints have to do with informed consent. The doctor's charts and records documented those discussions and the patient disputed them. In summary, Mr. Gaines urged the board to dismiss the case, not to entertain another appeal, and hopes the board will put an end to this case.

Robert P. Goldfarb, M.D. stated he knows Mr. Gaines and Dr. Adkins professionally, but it would not interfere with his ability to adjudicate the case.

J.S., complainant against Dr. Adkins, was present for the Call to the Public. J.S. quoted Dr. Adkins: "if it doesn't work you'll be no worse off". She said Dr. Adkins used these same words to persuade patient M.O. to also have surgery. J.S. stated this was the most

physically horrifying experience of her life. She expressed that she is a very angry patient and feels that a patient has rights to informed consent and proper medical care. J.S. shared the many roles she plays as a woman to protect the people she loves against doctors like Dr. Adkins. J.S. feels Dr. Adkins uses his medical license as a way of using human beings and tricking them into surgery with slogans. She stated that she was cut deeply without consent and was sent home with no discharge instructions. J.S. developed an infection and described in detail the symptoms and effects that were associated with the infection that lasted two months. J.S. was in extreme pain and contacted Dr. Adkins for help but he did not call her back. J.S. stated again that she did not consent to the procedure. She felt lured and trapped, and does not feel Dr. Adkins is fit to serve or teach medicine. J.S. said that she is not animal, she is a human being and her body was harmed, damaged, and changed forever. J.S. expressed her feelings towards Dr. Adkins and felt in her opinion that he should be charged and tried for assault and battery. J.S. informed the Board that an investigator never contacted her. She felt she was reduced by the Executive Director to a margin of error statistic, that it doesn't matter what the standard of care is, and that she was just a name on a piece of paper. J.S. conveyed that the Executive Director claimed her calls were routine. She listed symptoms of extreme pain, fainting and swelling and referred to the pathology report as hard evidence, which showed 1" of skin had been removed in reconstructive surgery. J.S. claimed the Executive Director informed her that she should have known the risks. She stated that she did not go to medical school and that the Board cannot blame her for not having independent knowledge of the medical risks. J.S. said that she left her first meeting with Dr. Adkins believing this was so insignificant that it was not worth fixing. She scheduled the second meeting a year later to address questions she had about the procedure. J.S. said that just because a patient is interested in information about a procedure it does not mean it is consent or that a doctor can mislead a patient into it. She said that Dr. Adkins knowingly gave her false answers. She asked where her questions were documented in the medical records. J.S. felt Dr. Adkins' records were a cover up. She felt he hid behind the Board and his attorney; her private records circulating in law offices, a profession she works in. In summary, J.S. stated she had reconstructive surgery; she still has pain, is changed forever, and has a list of problems. She repeated the slogan "if it doesn't work you'll be no worse off." After receiving the appeal, J.S., withdrew her appeal and made posters and picketed at TMC because she felt the Board does not protect the public. J.S. closed by expressing her disappointments toward the Board.

M.O., former patient of Dr. Adkins, was present at the Call to the Public. M.O. mentioned she received a phone call from J.S. this week and didn't know she existed. She apologized to J.S. for not bringing her own situation to the Board, which may have prevented J.S.'s harm. She noted that there are two of them who have experienced this and wondered how many before them, between them, and after them existed. M.O. described in detail a situation that occurred while sitting at her patio one morning, where she lost full control of her bowels. She described the mess it caused and the work that had to be done to clean it up. M.O. explained that this does not happen all the time, only six to eight times a month. She described the fear she lives with on an hourly basis wondering when it will happen again. M.O. described the different medications she takes, and the embarrassing uncontrolled symptoms she experiences on a daily basis. M.O said that it started with the birth of her second child when she had a tear. Within the year she went into a simple surgery where she was sewn up and everything was fine. She stated that fifteen years later she noticed a leak and followed up through her HMO who suggested biofeedback and diet. When nothing worked, she consulted Dr. Adkins who said, "…it won't get worse" with the surgery. M.O. explained how the surgery went from one day in the hospital to five days. M.O. said she was very sick and was not told about complications. It was explained to her that some people take longer to recuperate than others. After five days in the hospital she was released. That night at 1:00 in the morning, after falling asleep on the sofa, she lost full control of her bowels and was unable to make it to the bathroom in time. M.O. described the mess that it created and the difficulty, the expenses, and the embarrassment involved in cleaning it up. After three days of excruciating tests at Mayo Clinic, M.O. found out nothing could be done. M.O.'s Tucson Gynecologist referred her to another physician. M.O. stated that scar tissue had developed from the surgery making sexual intercourse extremely painful. Her physician was able to correct the problem somewhat with another surgery. M.O. sought out an attorney to pursue a lawsuit, but experienced difficulty finding a physician to testify on her behalf. As a result, she had to drop the lawsuit. M.O. mentioned that the effects of this have impacted her life emotionally, physically, psychologically and socially. Because of the fear and work involved, she does not have a social life. It upset M.O. that Dr. Adkins had the records of her lawsuit, knew that she focused on the fact that he said "It won't be worse", and then repeated the exact same thing to another patient. M.O. blamed the medical community along with Dr. Adkins for this situation. M.O. feels that doctors have a code of silence and expressed that it is despicable and believes the Board knows about it too.

This case was pulled for discussion. Tim B. Hunter, M.D. noted that the two women who came to the Call to the Public were extraordinarily upset. It caught his attention and felt it needed to be discussed.

Mark Nanney, M.D., Chief Medical Consultant, gave an overview of the case. He stated that there were four main complaints; informed consent was absent, the operative technique was below standard of care, the postoperative care was below the standard of care, and medical records were not provided in a timely fashion. In regards to informed consent, both the internal and external medical consultants found evidence of signed consent forms in the records. Dr. Nanny stated the medical consultant's reports were that the operative techniques were adequate. The patient requested medical records on September 10, 2003 and they were sent to her on September 12, 2003. Post operatively there were complications and the patient was unhappy with the outcome; however, both consultants found that the care was within the standard of care.

Tim B. Hunter, M.D. indicated that he felt sorry for the patients, and wished to convey the Board's appreciation for J.S. and M.O.'s suffering, and while what happened to them is unfortunate; the care was within the standard of care.

Dr. Lee asked how to handle if we continue to see these cases happen repeatedly from the same doctor. One to two events like this from a surgeon who does a lot of procedures falls within the norm. If the Board begins to see more than this how it should be handled. William R. Martin, III, M.D. felt the only way to trend these cases is through an advisory letter.

MOTION: Ram R. Krishna, M.D. moved to uphold the ED Dismissal.
SECONDED: Lorraine Mackstaller, M.D.

VOTE: 12-yay, 0-nay, 0-abstained/recused, 0-absent
MOTION PASSED.

The Board commented that it did not feel the doctor did anything wrong under the applicable standard of care, but did want to acknowledge the pain both ladies experienced. The women understandably had a great deal of anger at the situation, particularly J.S. with having cancer, and directed it at the Board. It was suggested that the final action notices that are sent to the complainant could be written so that the complainant knows the Board is sensitive to the situation. The Board has a lot of cases that are sensitive like this and it would be nice to handle these types of situations differently. The Board felt that these people needed to be acknowledged in some manner so that it changes the perception of the Board to the public.

The Board also felt that the physician that physicians who take time out from their practice to defend their cases also deserve a note of appreciation.

5.	MD-04-1348A	D.D.	CORALEE H. MCKAY, M.D.	17374	Uphold ED Dismissal
6.	MD-04-0185A	A.F.	KEITH CUNNINGHAM, M.D.	25186	Uphold ED Dismissal
7.	MD-04-0445A	M.F.	CAROL MCMULLIN, M.D.	16771	Uphold ED Dismissal

Dr. McMullin spoke at the Call to the Public. She explained the situation that occurred with the patient's visit and how the complaints were addressed, the review of the MRI, and how she referred the patient to a Gynecologist. She discussed the second visit, which was twelve days later, and once again the same process was done including the review of the notes in the record from the first visit. No new information was brought to the Board. Dr. McMullin asked for this appeal to be dismissed.

8.	MD-04-0445B	M.F.	STEPHANIE EVANS, M.D.	29793	Uphold ED Dismissal

M.F. spoke at the Call to the Public. M.F. is a 54-year-old woman, whose family's lives have changed since January 30, 2003 because a couple of doctors failed to take the time and hear what she was communicating. Dr. McMullan and Evans didn't take the time to review the x-ray that shows as she had tumors. The doctor said she instructed her to see a gynecologist, but she never said this. M.F. experienced hip pain in July of 2000 and has found literature showing it is rare, but she had complained of hip pain. She had seen an orthopedic specialist who prescribed an MRI. The orthopedic specialist said there was nothing wrong with her bones, but she had a growth on her uterus. Dr. McMullin and Dr. Evans made a judgment error in the standard of care that negatively has affected many lives. M.F. stated that she has an abdominal scar due to the infection from taking staples out too soon. She recommended that the Board ask these doctors perform at least thousand hours of community service at a cancer facility to see how the disease affects participants and their families. The oncologist did not listen to her needs, but based it on his dated information. M.F.'s subsequent physician, Dr. Elijah Carter, diagnosed the cancer and took the time to listen and restored her faith in doctors.

9.	MD-04-1293A	M.P.	MICHAEL CONWAY, M.D.	6878	Uphold ED Dismissal

Michael Conway, M.D. spoke at Call to Public. Dr. Conway treated M.P. in November 1, 2001 in the emergency room with acute gallstone pancreatitis. She underwent a cholecystectomy. Two weeks after seeing her, M.P. had no abdominal complaints and was back to her pre-hospital condition. On May 6, 2004 M.P. underwent a pelvic procedure because of left lower quadrant pain. At that time a very small clip was removed from her pelvis that was lying free on the left side of the pelvis. The complaint was that he negligently placed the clip in the left side of the pelvis at the time of the original procedure. Anatomically it is almost impossible to do. The clip he uses is a 1centimeter clip. The patient had prior left pelvic surgery in 1996. Clips can come lose during or after surgery, however these are titanium clips and are non-reactive. An anatomically a free-floating clip cannot cause abdominal pain. It was picked out of the area without any difficulty at the time of the procedure. Dr. Conway requested the board dismiss the complaint without any grounds.

10.	MD-04-0930B	T.H.	RHETT GMS. RIGGS, M.D.	68041	Uphold ED Dismissal
11.	MD-04-1171A	N.H.	THOMAS HARMON, M.D.	21601	Uphold ED Dismissal
12.	MD-04-0654A	D.S.	STEVEN J. HATTRUP, M.D.	16182	Uphold ED Dismissal
13.	MD-04-1381A	D.A.	G. ALAN BRACHER, M.D.	25624	Uphold ED Dismissal

MOTION: Patrick N. Dr. Connell, M.D moved to uphold the ED Dismissals numbers 1-13.
SECONDED: Ram R. Krishna, M.D.
12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

OTHER BUSINESS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-05-L023A	AMB	SATWANT G. KESWANI, M.D.	N/A	Offer a consent agreement for a license with an advisory letter. Dr, Keswani must also fill out an amended license application.

Satwant G. Keswani, M.D. spoke at Call to the Public. She clarified the issue regarding her license application. She stated that she failed to renew her license on time because of an overseas trip. She also practices in New Jersey and in New York. Dr. Keswani provided the Board with an article related to her work. Dr. Keswani also provided the Board with an overview of the malpractice case she was involved with that led to the Executive Director's denial of her license. She requested that the Board allow her to renew her license to practice in Arizona.

Michelle Semenjuk, Licensing Manager, presented the case to the Board. She stated that Dr. Keswani was licensed in Arizona from May 1984 to May of 2004 when her license expired. In July 1984 the New Jersey Board (NJ Board) issued a reprimand and a fine for establishing misleading circumstances surrounding Dr. S's consultation and for inappropriate billing. Dr. Keswani indicated to the NJ

Board that she introduced Dr. S as her college and endocrinologist. She did not inform the patients that he was not a physician unless they asked. Dr. Keswani submitted to the NJ Board that she submitted bills for Dr. S's consultations without indicating that Dr. S. was not a physician. There were several billing issues in the order. Dr. Keswani did not disclose this information to the Arizona Medical Board. Dr. Keswani submitted an application in October 2004 and she did not disclose any of this new information on her application. Licensing received this information from the Federation of State Medical Boards (FSMB) and the NJ Board. The Executive Director has denied her license and she is now appealing that decision.

Tim B. Hunter, M.D. asked if Dr. Keswani checked no on all the bi-yearly applications that there has been no action against her. Ms. Semenjuk said that recently it has always been checked "no" because the questions are geared toward "since your last renewal". Past renewal applications are not available. An investigation has never been opened on Dr. Keswani; however, if the Board had received the information from the NJ Board it would have opened an investigation.

Sharon B. Megdal, Ph.D. noted that if Dr. Keswani had applied for renewal before her license expired the Board would never have discovered the NJ Board action. Lorraine Mackstaller, M.D. noted that it occurred in 1983 and that it was the only issue. In listening to her testimony, Dr. Hunter, found that she was in good standing and finds it difficult to deny her a license.

Ram R. Krishna, M.D. asked if a disciplinary action stays on a physician's record forever. Ms. Semenjuk stated that the action remains with the FSMB forever. It is up to the individual states to determine whether the action remains on their physician profiles.

The Board discussed the process for applicants who fail to disclose truthful information on their application. It was determined that if the information that was not disclosed had prevented the applicant from obtaining a license, they would have been issued a license with a disciplinary action. This would have been offered by consent

Dr. Goldfarb discussed Dr. Keswani's testimony at the Call to the Public. Stephen Wolf, Assistant Attorney General, felt that Dr. Keswani thought her record was not a disciplinary action against her license. She just paid a fine and that was it. However, New Jersey had found her guilty of some form of unprofessional conduct.

Tim B. Hunter, M.D. felt Dr. Keswani has an exemplary past and suggested offering her a consent agreement with a license and a letter of reprimand.

MOTION: Robert P. Goldfarb, M.D. moved to offer Dr, Keswani a consent agreement for a license with a Letter of Reprimand. Dr, Keswani must also fill out an amended license application.
SECONDED: Patrick K. Connell, M.D.

Dr. Goldfarb clarified that if Dr. Keswani turns down the Letter of Reprimand she would not be granted a license.

Dr. Krishna felt the Board should grant the license without a disciplinary action. Dr. Keswani did check with licensing and because licensing said the Arizona Medical Board only reports the last five years she answered based on what she was told. Ms. Cassetta pointed out that the application does cover all periods of time as it relates to discipline; the five year limitation is not applicable to that question. Ms. Semenjuk felt that Dr. Keswani probably did misunderstand the questions and in her defense feels she probably did think she answered honestly.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, and Dona Pardo, Ph.D., R.N. The following Board Members voted against the motion: Ingrid E. Haas, M.D., Tim B. Hunter, Honorable Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., and Sharon B. Megdal, Ph.D.
VOTE: 4-yay, 8-nay, 0-abstained/recused, 0-absent
MOTION FAILED.

MOTION: Sharon B. Megdal, Ph.D. moved to offer a consent agreement for a license, for an advisory letter. Dr. Keswani must also fill out an amended application.

The Board agreed that if Dr. Keswani turns down the consent agreement she would not be granted a license.

SECOND: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick K. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Honorable Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., and Sharon B. Megdal, Ph.D. The following Board Member voted against the motion: Dona Pardo, R.N., Ph.D.
VOTE: 11-yay, 1-nay, 0-abstained/recused, 0-absent
MOTION PASSED

2.	MD-04-L134A	AMB	HARRY GOLDENBERG, M.D.	None	Uphold Appeal of ED Denial of License with modifications to include A.R.S. 32-1401(27)(jj)

Michelle Semenjuk, Licensing Manager explained that Dr. Goldenberg applied for an Arizona Medical license and the license was denied by the Executive Director. Harry Goldenberg, M.D. sent in his appeal on July 12, 2005. He retained an attorney who contacted the Board August 9th, 2005 and stated that he wanted to appeal. Ms. Semenjuk informed the attorney that Dr. Goldenberg had already

appealed and as per statute he was placed on the next agenda and could not be postponed. The attorney requested that he be postponed again in writing and stated that the doctor was never noticed.

Ms. Semenjuk explained that Dr. Goldenberg was placed on probation in Fulton County during his residency for writing prescriptions of Percadan for his own use. His license in Massachusetts was placed on a stayed suspension upon entry into a probationary agreement. Dr. Goldenberg violated the terms of his probation and entered inpatient treatment, which he did not list on his application or on his application materials. The Massachusetts Board placed him on probation for as long as he holds a Massachusetts license. Dr. Goldenberg relapsed and entered another treatment program and surrendered his DEA license.

Tim B. Hunter, M.D. asked if the Board could postpone hearing the appeal until October and supported postponing the discussion. William R. Martin, III, M.D. stated that after reading the materials he comfortable with denying the appeal and is not in favor of postponement. Douglas D. Lee, M.D. concurred with Dr. Martin. The Board discussed concern about giving the doctor and his attorney their chance to present their case. Sharon B. Megdal, Ph.D. considered postponing the case. Dr. Martin reminded the Board that counsel could have been present today if he chose. Ms. Cassetta noted that Dr. Goldenberg did not tell the Board about both relapses on his application.

MOTION: Sharon B. Megdal, Ph.D. moved to uphold the Executive Director dismissal of licensure with modifications to include the withholding of information on the application. A.R.S. 32-1401(27)(jj).
SECONDED: William R. Martin III, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick K. Connell, M.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, R.N., Ph.D. The following Board Member voted against the motion: Ronnie R. Cox, Ph.D.,
VOTE: 11-yay, 1-nay, 0-abstained/recused, 0-absent
MOTION PASSED

3.	MD-04-0333A	AMB	MARY GROVES, M.D.	30315	Deny the Appeal of ED Interim Order and Issue Interim Order to be completed within 45 days of the date of the Order.

John D. Herbert, attorney for Mary Groves, M.D. was present for the Call to the Public. Mr. Herbert stated this was a written objection to an interim order, which mentioned perspective surgery on behalf of Dr. Groves. Dr. Groves underwent hip surgery late in July. It is anticipated she will be home recuperating for 8 weeks. The other basis for the objection of the written order is stated as written.

F.G. was present for the Call to the Public. F.G. wanted to bring to the attention of the Board the pain that Dr. Groves is in. The surgeon told her that she should stay off her hip for a week and then do some swimming exercises. She tried to do this for the last three or four days and found that it was too painful. She has been unable to function, which is why she was unable to appear today. F.G. felt it would be 8 weeks or more of recovery because it was a drastic surgery.

Board went into Executive Session at 5:45 p.m.
Board returned to Open Session at 6:06 p.m.

MOTION: Patrick K. Connell, M.D. moved to deny the appeal of the ED Interim Order and reissue the interim order for an evaluation to be completed within 45 days from the date of the Order.

Patrick N. Connell, M.D. stated that the hip surgery was conducted on July 27, 2005 so that this should be enough time for Dr. Groves to recuperate.

SECONDED: Douglas D. Lee, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Lorraine L. Mackstaller, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, Ph.D., R.N.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED

4.	MD-04-0666A	R.S.	JOHN W. MCGETTIGAN, JR., M.D.	12606	Approve Draft Finding of Facts, Conclusion of Law and Order for a Letter of Reprimand for deceptive or misleading advertising. Two years probation to obtain 20 hours of CME in ethics.

5.	MD-03-0897A	M.H.	RANDI GERMAINE, M.D.	21309	Approve Draft Finding of Facts, Conclusion of Law and Order for Letter of Reprimand for excessive prescribing. One-year probation and 90 days, from the effective date of the order, to obtain 20 hours of CME.
6.	MD-04-0270A	AMB	GEORGE A. DAVIDSON, M.D.	13477	Approve Draft Finding of Facts, Conclusion of Law and Order for Letter of Reprimand for failure to manage labor and delivery in a timely manner resulting in the death of an infant.

MOTION: Ingrid E. Haas, M.D. moved to approve the Draft Findings of Facts, Conclusions of Law and Order
SECONDED: Sharon B. Megdal, Ph.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED

7.	MD-03-0432A	AMB	MARY C. MICHELIS, M.D.	28955	Deny Motion for Rehearing/Review Denied.

Steven Wolf, Assistant Attorney General, stated that Mary Michelis, M.D. either lied when she checked "no" on her application or she lied when she signed her name certifying that she has reviewed the form and the information is correct. She knowingly made a false statement. Tim B. Hunter, M.D. stated that if someone else filled it out and she signed it would it be a consideration. Mr. Wolf did not find that to be credible.

Dr. Megdal said because of the way the physician's motion was written it appeared as though the physician's motion came from the Attorney General. Ms. Cassetta confirmed that the way the physician's motion was written it made it appear as though the Assistant Attorney General conceded her argument.

MOTION: Ram R. Krishna, M.D. moved to deny the motion for rehearing/review.
SECONDED: Patrick N. Connell, M.D.

Tim B. Hunter, M.D. noted physicians do not understand the consequence of filling out the application incorrectly and physicians should not rely on others to fill applications out for them.

VOTE: 12-yay, 0-nay, 0-abstain/recuse, 00-absent
MOTION PASSED

8.	MD-04-0843A	AMB	DEBORAH S. GOLOB, M.D.	31682	Deny Petition for Rehearing/Review

Steven Wolf, Assistant Attorney General stated that the argument made by Dr. Golob's counsel does not have much legal basis and that regardless of the Board's decision, it is likely the physician would appeal the matter to Superior Court.

MOTION: Sharon B. Megdal, Ph.D., moved to deny the motion for rehearing/review.
SECONDED: Patrick N. Connell, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED

9.	MD-04-1489A MD-03-S009A	AMB	WILLIAM J. CASEY, JR., M.D.	9866	Accept Proposed Consent Agreement for license surrender.

Lorraine Mackstaller, M.D. and Dona Pardo, R.N., Ph.D. recused themselves from this case.

10.	MD-03-0598A	AMB	DAN S. MALLADA, M.D.	25763	Accept Proposed Consent Agreement for stayed license revocation for one year, as amended

Sharon B. Megdal, Ph.D. noted that the probationary term, as drafted, is not clear. She asked that Board staff amend the probation to state that it would end when the term of the California probationary term ended.

MOTION: Sharon B. Megdal, Ph.D., moved to accept the proposed consent agreement as amended.
SECONDED: Douglas D. Lee, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Lorraine L. Mackstaller, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, Ph.D., R.N.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED

11.	MD-04-1403A	AMB	JOHN F. KREMPEN, M.D.	8444	Offer the physician an amended consent agreement for a Letter of Reprimand and 1 year Probation to include a board approved CME course in ethics. Physician The probation will not terminate upon completion of the CME. If doctor refuses he will be invited for a formal interview.

Sharon B. Megdal, Ph.D. pulled this case for discussion. Dr. Megdal stated that she remembered Dr. Krempen well as he been before the Board several times since her time on the Board. This case shows a blatant disregard for the value and the legal requirements for continuing medical education. Dr. Megdal does not believe the sanction is strong enough for Dr. Krempen. With his record, she questions his fitness to practice medicine.

Dr. Krishna stated that this is not a quality of care issue. Ms. Cassetta said the statute requires the Board to review prior actions even though it is not a quality of care issue.

Dr. Goldfarb suggested adding probationary period and an adding an ethics course.

MOTION: Dr. Sharon B. Megdal, Ph.D., moved to offer the physician an amended consent agreement for a Letter of Reprimand and 1 year Probation to include a board approved CME course in ethics. Physician probation will not terminate upon completion of the CME. If doctor refuses he will be invited for a formal interview.
SECONDED: Douglas D. Lee, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Lorraine L. Mackstaller, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, Ph.D., R.N.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED

12.	MD-04-1528A	AMB	LOUIS MILLER, M.D.	23201	Accept Proposed Consent Agreement for Letter of Reprimand for failure to provide medical records in a timely manner after receiving an appropriate request.

Ram R. Krishna, M.D. recused himself from this case.

13.	MD-04-1142A	AMB	GERALD ROUNSBORG, M.D.	8162	Accept Proposed Consent Agreement for license surrender.

MOTION: Sharon B. Megdal, Ph.D., moved to approve the Proposed Consent Agreements for cases 9, 12 and 13.
SECONDED: Douglas D. Lee, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Lorraine L. Mackstaller, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, Ph.D., R.N.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent (Dr. Mackstaller and Dr. Pardo recused from case #9 and Dr. Krishna recused from case #12)
MOTION PASSED

14.	MD-01-0577	B.N.	ROBERT MCCREA, M.D.	21109	Rescind Referral to Formal Hearing/Proposed Consent Agreement for Decree of Censure for falling below the standard of care in failing to treat Patient W.N.'s pregnancy induced hypertension vigorously to prevent cerebrovascular event that resulted in her death.

Dean Brekke, Assistant Attorney General, stated that this case was referred this for a formal hearing. Dr. McCrea agreed to enter into a consent agreement for a Decree of Censure. Mr. Brekke felt it was a fair consent agreement for the offense and asked the Board to rescind the referral to formal hearing and accept the proposed consent agreement.

MOTION: Sharon B. Megdal, Ph.D., moved to accept consent agreement and rescind the referral to formal hearing.
SECONDED: Douglas D. Lee, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Lorraine L. Mackstaller, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, Ph.D., R.N.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED

16.	MD-04-1374B	D.F.	LUIS A. MUNOZ, M.D.	9794	Deny the E.D. Dismissal and re-agendize this case for an advisory letter.

D.F., complainant against Luis A. Munoz, M.D., was present for the Call to the Public. D.F. said that the Board had reviewed his case and stated that it was his understanding that the Board would obtain all of his records from the nursing home.

D.F. reiterated that he is still disabled and is a cripple for the rest of his life. He stated that is unable to do any of his hobbies such as running, prolonged walking, or bowling. D.F. said he contacted the Arizona Hospital Accreditation board and they are investigating who was responsible for his staph infection. His lawyer did not have time to go over the case. D.F. appeals this case at this time.

This case was pulled for discussion. Robert P. Goldfarb, M.D. recalled the concern about the ciprofloxacin antibiotic coverage. William Wolf, M.D., Board Medical Consultant, stated that he was convinced the patient was on the proper antibiotic. Dr. Goldfarb asked if the Ciprofloxacin medication the doctor placed him on was within the standard of care. Dr. Wolf did not feel it was within the standard of care. The plan had been to transfer care of the patient to another physician because he gave up on the cause. Dr. Goldfarb stated that even if the doctor gave up he still prescribed a medication. The patient was only on ciprofloxacin for three days before he was transferred and it did not affect the outcome.

MOTION: Ram R. Krishna, M.D. moved to deny the dismissal and re-agendize this case for an advisory letter.
SECONDED: Robert P. Goldfarb, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED

15.	MD-04-1374A	D.F.	LUIS A. COPPELLI, M.D.	9535	Dismissed.
17.	MD-03-0337A	K.T.	WILLIAM D. MARCHESKY, M.D.	15907	Dismissed.

Patrick N. Connell, M.D. recused himself from this case.

18.	MD-03-1114A	P.W.	STEPHEN D. GLACY, M.D.	1782	Dismissed.

MOTION: William R. Martin, III, M.D. moved to dismiss cases 15-18.
SECONDED: Patrick K. Connell, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent (Dr. Connell recused himself from case number 17)
MOTION PASSED

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-04-0916A	AMB	ASHRAF A.S. GERGES, M.D.	25594	Dismissed.

Ingrid E. Haas, M.D. stated for the record that she knows Paul Giancola, attorney for Dr. Gerges, but it would not influence her ability to adjudicate this case.

Dr. Gerges was present with legal counsel, Mr. Paul Giancola.

Kelley Sems, M.D., Medical Consultant presented an overview of the case. The case was brought to the Arizona Medical Board on July 15th, 2004 as a result of a malpractice settlement notification. Dr. Gerges allegedly failed to diagnose and treat necrotizing fascitis resulting in an above-the knee amputation of the right leg. It was also alleged that he failed to refer the patient to an appropriate specialist in a timely manner and that Dr. Gerges altered and/or destroyed the medical record in order to conceal malpractice. The allegation that Dr. Gerges altered and/or destroyed the record was reported to the Board previously and was adjudicated separately in case MD- 03-0170. With regards to the allegations, the opinion of the Board's medical consultant was that Dr. Gerges deviated from the standard of care by not performing a more aggressive treatment and workup of the patient's condition. Patient R.K. lost his lower extremity as a result of Dr. Gerges' failure to diagnose necrotizing fascitis. The Staff Investigational Review Committee felt the doctor should receive a Letter of Reprimand.

Dr. Gerges stated that he had only seen patient R.K. three times. The first time was because the patient's primary care physician wasn't available at the clinic. On that day, R.K. had swelling in his right leg and after speaking to the patient, Dr. Gerges referred him to the emergency room. From that point on, R.K. saw an orthopedic surgeon as per the records. That was on September 12th. After that, R.K. was seen by Dr. Michael Dersam who aspirated the knee, did an MRI, did an x-ray, took blood cultures, placed the patient in an immobilizer, and asked the patient to follow-up the next day. Per Dr. Dersam's records, the patient did not follow-up. Dr. Dersam said the patient had cancelled office visits over weekends. Dr. Dersam instructed R.K. to go to the emergency room for a consultation. R.K.'s wife called Dr. Gerges and said that overall R.K. had improved and was not in pain. R.K. and she did not feel he needed to come in. Dr. Gerges informed the patient and his wife at that point that he still wanted to see them for a follow-up visit. The wife said she would schedule an appointment after she talked to R.K. She also mentioned to the practice manager that she was tired of coming to the physician's offices and she felt that things were getting better and would rather wait to come in. Later she apologized to Dr. Dersam for not coming in and felt she had let Dr. Gerges and her husband down.

Dr. Gerges reiterated that the patient was referred to the orthopedic surgeon on the first day that he saw him and he was treated appropriately. When R.K. went to the emergency room he had all of the tests to rule out the most imminent danger, including deep vein thrombosis (DVT). From then on he had a heart workup and a full blood workup. R.K. then followed up with the orthopedic surgeon. R.K. did not follow up again until two to three days before the procedure took place. Dr. Gerges pointed out to the Board that

necrotizing fascitis is an infection that develops over hours, not weeks or days. Dr. Gerges last saw R.K. on September 30th and ordered a CPK level, which was normal. Consistent with necrotizing fascitis, where the muscle dies, the CPK gets markedly elevated. This indicates that it is highly likely that the incident happened two to three days before R.K. came to the hospital. Dr. Delaney is one of the 11 specialists that R.K. saw. Her records state that R.K. started to deteriorate two to three days before he came to the hospital. Dr. Gerges saw the patient on September 30th, and the patient went to Scottsdale Hospital on October 5th, which shows that when Dr. Gerges last saw the patient he did not have necrotizing fascitis. Dr. Gerges stated the second thing he did was place the patient on antibiotics. He put R.K. on Augmentin at high doses because this was the antibiotic that the tissues (from the tissue culture) were sensitive to.

After reviewing three different sources (Cecil, Davidson, and Harrison), Dr. Gerges said they all agreed that this is a formulating infection ranging between 12 and 36 hours. Dr. Gerges also referred to two textbooks regarding necrotizing fascitis.

In neither textbook, *The Atlas of Primary Care Procedure* by Dr. Zuber nor *The Primary Care Physician,* does it talk about a family physician doing a necrotizing fascitis procedure. Because necrotizing fascitis is an operative diagnosis, the surgeon thought the patient had cellulites; he did not know the patient had a necrotic leg. This was even after the workup, after two orthopedic surgeons and a general surgeon had seen him and after he drained the abscess and saw the necrosis in the muscle.

William R. Martin, III, M.D. led the questioning, focusing on understanding the records and Dr. Gerges' interpretations of them. In the letter from Dr. Gerges to the Board dated September 3, 2004, Dr. Martin referred to the vein stripping procedure. Dr. Gerges stated the procedure had been performed when R.K. had bypass surgery in August 2002. Dr. Gerges confirmed for Dr. Martin that the procedure was not for venous regurgitation, but was to harvest the graft for the bypass procedure. Dr. Martin requested Dr. Gerges to describe how the procedure would impact the patient's ultimate diagnosis and course. Dr. Gerges said that it affects the vasculature of the lower extremity. When the outer vein is stripped, it leaves a deep vein and for an uncontrolled diabetic there is a vascular compromise related to that. Dr. Martin questioned if having that knowledge changed the manner in how to approach the patient and treatment plan. Dr. Gerges replied that he was aggressive the minute he saw the patient and referred R.K. to the emergency room. He spoke to the emergency room doctor, Dr. Keith Butler, at the Arizona Heart Hospital around 4:00 or 5:00 in the afternoon. Dr. Gerges stated that because of the vein stripping procedure, and other things, that he had a high index of suspicion and had an earlier referral.

Dr. Martin questioned details relating to the MRI. Dr. Gerges stated Dr. Michael Dersam, the orthopedic surgeon, ordered the MRI the same day prior to the amputation surgery. The MRI findings were consistent with a gastrocnemius torn muscle. Dr. Gerges did not review the MRI and did not have access to the data while treating the patient. During the second visit with Dr. Gerges, the patient informed Dr. Gerges of the gastrocnemius tear and other tests that had been performed at the emergency room. Dr. Gerges knew that Dr. Dersam was following-up with the leg, but Dr. Gerges was responsible for controlling other risk factors.

Dr. Martin asked Dr. Gerges to explain what he would expect a leg to look like if it had a muscle tear. Dr. Gerges described it as looking similar to an infection, it would be swollen, have localized tenderness, it would be difficult to walk on, and there would be difficulty of movement of the attached muscles, an intact neurovasculature. If a subcutaneous hematoma were present then there would be hotness, tenderness, and the signs of an infection. Dr. Martin questioned an elevated white count. Dr. Gerges said the tests he performed on September 30th showed a normal white count. Dr. Martin questioned other symptoms such as nausea, vomiting, fever, or chills. Dr. Gerges replied that it would not necessarily be so because it denotes a toxic manifestation of some sort and the patient did not have any of those symptoms on the first visit. The patient had been eating and had not complained of anything. It wasn't until October 3rd that he started to get toxic.

Dr. Martin questioned venous duplex. Dr. Gerges confirmed this was to rule out DVT. Dr. Gerges confirmed if a physician looked high up enough he could expect, during a venous duplex, to see hematoma associated with a muscle tear in the leg. The report showed that he did not have any DVTs and did not mention anything about other hematomas or anything else associated.

Dr. Martin questioned, from the letter, Dr. Gerges comments regarding controlling R.K.'s sugar levels. Dr. Gerges felt as the primary care physician that it was part of his responsibility to take care of those. Dr. Martin asked Dr. Gerges to explain some of the reasons a patient would have difficulty maintaining control of sugar levels. Dr. Gerges stated that on August 11th the patient saw an endocrinologist, Dr. Plummer. R.K. told Dr. Plummer that he had been receiving testosterone injections, but he would not identify the doctor. He continued to see Dr. Plummer and she had noted that he had a stroke in January 2001 and at the same time was diagnosed with diabetes. Dr. Plummer said that he now had uncontrolled diabetes and she instructed R.K. to get a blood glucose monitor but he did not. This was the day before Dr. Gerges saw the patient. Dr. Gerges felt that the testosterone injections, not monitoring blood glucose, along with lack of exercise, bad diet, and infection could cause problems with maintaining blood sugar elevation. Dr. Martin asked if varying degrees of sugar in the patient could have been associated with an infection back in the early part of September. Dr. Gerges felt looking back that it could have been, but he didn't have the classic white count it was normal. The white count on the 5th was 9.2 and it was normal. Dr. Martin questioned if it is possible for a white count to be unreliable in a patient who is immunosuppressed. Dr. Gerges stated the patient was not having chemotherapy and his immune system could be compromised by another associated clinical picture. He felt eventually one would have a clue. Dr. Gerges explained the scenario with Dr. Dersam again explaining how, based on the MRI, they ruled out the major things, leaving them to treat the gastric tear.

Dr. Martin questioned Dr. Gerges regarding concerns about possible compartment syndrome and/or infection and asked how he went about treating it. Dr. Gerges stated that he referred R.K. to an orthopedic surgeon because as a primary care physician he is not trained to do surgery. Dr. Martin asked Dr. Gerges to explain the standard of care. Dr. Gerges felt the standard of care was to refer him for an orthopedic evaluation, which he did do. Dr. Martin questioned Dr. Gerges on his knowledge and understanding of necrotizing fascitis. Dr. Gerges replied that it occurs over hours. Dr. Gerges was convinced that this was not necrotizing fascitis.

Robert P. Goldfarb, M.D. referred to the facility medical records and asked Dr. Gerges about his practice with Family Practice Specialist LTD. Dr. Gerges said he practiced in their office, but did not have an agreement or a contract. He left the group around November or December of 2002. Dr. Gerges was at the office during the time the event occurred. Dr. Goldfarb directed Dr. Gerges to the note dictated on October 7, 2002 and asked how he dictates these notes. Dr. Gerges replied that he usually dictates real-time or within the same day. Dr. Goldfarb read a portion of the note where Dr. Gerges learned that the patient was going to have the right leg amputated and he checked in on the patient and his wife. Dr. Goldfarb questioned if the note was written in retrospect and that he addressed recollections of past events. Dr. Gerges explained that this note was a progress note, a cover letter, or an overview note. Dr. Goldfarb asked Dr. Gerges to testify under oath that this note of October 7, 2002 was dictated on that date and is authentic. Dr. Gerges replied that if it has his signature then it was. Dr. Goldfarb asked again if it was absolutely authentic and had not been edited. Dr. Gerges said that it was dictated on October 7th and had not been changed or altered in anyway.

Tim B. Hunter, M.D. asked Dr. Gerges, knowing what he knows happened to the patient, what if anything would he have done differently? Dr. Gerges said he asked himself this many times. He referred the patient immediately, controlled the diabetes to decrease risk factors, he controlled his infections with Augmentin. Dr. Gerges could not see anything else he could have done.

Ram R. Krishna, M.D. asked when Dr. Gerges realized there was a possible ulcer on the back of the leg or cellulites if he made the call or if he told the patient to see somebody. Dr. Gerges replied that the patient said he would follow-up with an orthopedic surgeon. He put the patient on antibiotics to cover for both the sinus infection and suspected leg infection. Dr. Gerges was aware that an antibiotic would not work on an abscess. Dr. Gerges contacted Dr. Dersam, the orthopedic surgeon, and was told they had followed-up with the patient. The patient had claimed he was feeling better and decided not to go in, but Dr. Gerges did not feel the patient was getting better. Dr. Krishna asked how Dr. Gerges handled the patient when he was non-compliant. Dr. Gerges said he did not send any records over and he only made the one call. He said the patient had a long record of non-compliance with him and other doctors. He would not take medications, would not pick them up, and at times would stop taking his diabetic medications. Dr. Krishna asked Dr. Gerges if he felt it would have made a difference in the surgeon trying to contact R.K. if Dr. Gerges had called and expressed to the orthopedic surgeon that this patient was not doing well and had a history of non-compliance. Dr. Gerges felt he did what he should have done and noted that the surgeon made several attempts to contact the patient and was unable to reach him.

Dr. Goldfarb asked why Dr. Gerges started the patient on antibiotics. Dr. Gerges said it was because of the infection with the U.R.I and to cover a possible infection. Dr. Gerges said the leg was still tender, red, and swollen and wasn't improving so he felt prompted to start him on antibiotics. Dr. Goldfarb asked Dr. Gerges to explain why he did not contact the orthopedic surgeon. Dr. Gerges said it was because he knew the orthopedic surgeon wanted to see the patient again and said they would follow-up. Dr. Goldfarb asked if Dr. Gerges had experience with this patient before. Dr. Gerges explained that he had only seen him three times and that R.K. was not his patient. Dr. Goldfarb asked how Dr. Gerges, with R.K.'s history of non-compliance issues would think the patient would follow-up with the surgeon. Dr. Gerges stated that he felt after putting him on the antibiotics and instructing him the patient would follow-up. Dr. Gerges did not feel he had any other options and felt he would have made things worse if he attempted to correct the problem himself. Dr. Goldfarb asked if he sent the patient to the emergency room on September 30th and Dr. Gerges stated he did.

Mr. Giancola, attorney for Dr. Gerges, made his closing remarks and gave a summary of everything that was discussed in the interview. He referred the Board to tab 9 of a document that the plaintiff presented to this board, where it states "unaltered medical records" and a reference to Dr. Gerges' phone call on October 3rd where Dr. Gerges advised him to go to the emergency room. The patient admitted to Dr. Gerges that he underestimated the seriousness of his condition. Dr. Dersam also wrote in his office records a similar note on October 8, 2002, where he talked to the wife who apologized for underestimating the seriousness of the condition. The Scottsdale emergency room records show that they originally thought he had a stroke when he was admitted to surgery. It was during surgery that they discovered the necrotizing fascitis. The patient did not have the ability to fight off the infection and required amputation. Dr. Curry did an external review (records were submitted) and stated that it was a difficult diagnosis and it was not an untimely diagnosis by Dr. Gerges. Dr. Curry felt that Dr. Gerges did meet the standard of care. Dr. Goldfarb asked for clarification on the dictation on tab 9 and on tab 7. Dr. Goldfarb pointed out that there are two records and wanted to know which one was the correct one. Dr. Gerges said if it did not have his signature that it is not his record. The only record he has is the one with his signature. Any other record is not his. The correct, authentic record is the one in item 7 that has his handwriting on the side.

Dr. Martin felt that during the interview Dr. Gerges did know what the standard of care was and was satisfied with the answers. Dr. Martin felt the dual records issue was distracting, but it is not the reason for this interview. He feels that it is the responsibility of the physician, in a complex situation and where a patient is non-compliant, to tell a patient to see a specialist or emergency room and make an additional phone call to a referring physician. This did not happen in this case. On the other hand, the patient also has a responsibility to accept the care being offered to them and follow-up to comply. The standard of care for a primary care physician in a patient who has a suspected compartment syndrome and/or infection is early referral. This standard of care was met.

MOTION: William R. Martin III, M.D., moved to dismiss the case.
SECONDED: Becky Jordan
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Lorraine L. Mackstaller, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, Ph.D., R.N.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-04-1154A	S.G.	WILLIAM B. DABNEY, M.D.	5796	Advisory letter for improper management of a patient with symptomatic bradycardia. There is insufficient evidence to support discipline.

Dr. Dabney was present with legal counsel, Mr. Brian Schulman.

Dr. Goldfarb stated that Gallagher and Kennedy law firm has done corporate work for his group. He does not know Mr. Schulman and has not met him and it would not influence his ability to adjudicate this case.

Dr. Huber presented the case. The 74-year-old female patient complained in mid-September of last year that Dr. Dabney had not adequately evaluated her bradycardia, her possible coronary problems, and had not referred her to a cardiologist. A Board medical consultant reviewed the case and felt that the standard of care would be to appropriately evaluate the problem of bradycardia, taking into consideration, history, physical, EKG, and other lab work. He felt a cardiologic referral might be indicated. The patient's daughter reported the problem to Dr. Dabney. It was three days before the patient was seen in the office. Dr. Dabney recognized that there was a problem of heart block and a potential of a complete heart block situation, but did not refer the patient, nor did he order any specific treatment beyond recommending that the patient get more exercise. About four days later, the patient had to go to the emergency room and wound up getting an implantable pacemaker for a second-degree heart block situation. The medical consultant felt that Dr. Dabney had not done a sufficient evaluation.

Dr. Dabney made an opening statement. Dr. Dabney has known S.G. for approximately 11 years. He has been her physician through many medical problems. On the 25th the patient phoned Dr. Dabney and informed him that she was concerned, being short of breath and also quite dizzy. This had been a common complaint of S.G. and she had just been put on thyroid medication approximately a month before. The patient was concerned that the thyroid medication might be causing some of the problem. Dr. Dabney documented in a note that he suggested cutting the thyroid medication in half and asked the patient to come in on Monday (the next day). S.G. called while Dr. Dabney was in the emergency room, so his staff recommended (since he was heavily booked) that she go to the emergency or come in the next day. S.G. came in the next day, which was July 27th. The patient complained of dizziness and shortness of breath. She said she had not had any shortness of breath with walking for the last two days. Dr. Dabney carefully examined her. Her initial pulse was 50. He immediately rechecked it and it was then 80 per minute. He found nothing up to that point in the physical. Dr. Dabney did an electrocardiogram and found it had not changed much since 1998. She had a block that had been present since 1998. There were a couple of variants, but not enough to say she had second-degree heart block. Dr. Dabney considered a possible anginal variant with dyspnoea. He documented that he was considering heart block. Dr. Dabney did this so that if another physician were treating S.G. in his absence (he works in a group) they would consider this in their course.

Dr. Dabney said that S.G. had Meniere's disease, hearing loss, tinnitus, and a lot of dizziness. She was concerned about falling and asked what she should do if she walked. He instructed her to use a cane and be careful not to fall. Dr. Dabney also warned her if it should recur or if it continues to go to the emergency room or call him. Dr. Dabney stated that in his dictation was cut off right after he instructed her to go to the emergency room. He felt up to this point in the dictation that his care was appropriate considering what he knew, what he examined, and what he found. Dr. Dabney noted that in Prescott, most of the physicians do their own cardiology. He admits to ICU, he does treadmills, stress echoes, and cardiology consultation when necessary. Dr. Dabney believed his care was appropriate for this date.

Patrick N. Connell, M.D. started the questioning by asking if the phone call on July 25, 2004 was documented. Dr. Dabney stated that it was documented in a phone log and pasted in the patient's record. Dr. Connell asked Dr. Dabney how Meniere's disease was established in S.G. Dr. Dabney stated that S.G. had come in several months prior with persistent vertigo, tinnitus and hearing loss. He recommended she have some procedures (hall bright maneuvers and Epsom maneuvers) done to treat this and she did not follow up. Dr. Connell referred to the visit on July 27, 2004 where the patient complained of vertigo and dyspnoea that had occurred on the 25th. Dr. Dabney stated that she had dyspnoea before, but had not complained about it for some time. He confirmed it was an isolated episode that cleared. Dr. Connell asked Dr. Dabney to define the standard in family practice for the workup of dyspnoea in a 74-year-old patient with multiple medical problems. Dr. Dabney said that there could be multiple causes. In a lady who has a smoking history, is very depressed, and has a condition that was dealt with several times. It can also be an anginal variance. Dr. Connell asked Dr. Dabney to describe how he addressed the issue of anginal variant. Dr. Dabney said he examined her, and carefully questioned her, and he did a cardiogram. He felt he needed more persistent symptoms to go further. She had been worked up in 2001 with stress echo and Dr. Dabney had seen her through several situations concerning her vascular system. Dr. Dabney stated that on July 2000 he did not address the issue of chest pain because the patient did not complain about it. Dr. Connell asked if a patient with chronic factors, dyspnoea, and chest pain should be addressed at some point and Dr. Dabney stated that it should.

Dr. Connell asked if a resting 12 electrocardiogram is a good screening tool for an acute process in a patient with left bundle branch block. Dr. Dabney replied that it had its limits and some times acute changes could not be seen on the cardiogram. Dr. Dabney stated that with someone having an acute ischemia or acute myocardial infarction (MI) one might not be able to diagnose it given the left bundle branch block. Dr. Connell asked Dr. Dabney to list the characteristics of sick sinus syndrome. Dr. Dabney stated that a patient could have varying heart rates upon examination and can be symptomatic and syncopal. Dr. Connell pointed out that the patient had a variance from 50 to 80 in the examination. Dr. Dabney said he wasn't convinced at the time that this was a correct reading and when he examined her it never fell below 68.

Dr. Connell asked what the standard of care in family practice is for a 74-year-old with multiple medical problems when you suspect there might be complete heart block. Dr. Dabney stated the appropriate response is to admit the patient in the intensive care unit and consider a pacemaker. He stated that on the 27th, based on her cardiogram, pulse rates, and oxygen saturation, he did not feel she had second-degree heart block or complete heart block and did not need to be admitted for further pacemaker placement. Dr. Dabney

stated the patient was in the office for about 30 minutes and felt this was enough time to adequately monitor her symptoms. He did consider putting her on a monitor, but didn't and felt if it persisted then he could do that.

Dr. Connell inquired about the medication S.G. was on and asked what type of medication it was and what the contraindications of Verapamil are. Dr. Dabney said that it is a channel blocker and that she had been on this for a period of time. The dose had been reduced at one time. He stated the contraindications are if the heart rate changes or there are contraindications with other medications, such as sick sinus syndrome, and also second or third atrial valve (AV) block would also be contraindication. Dr. Connell asked how prescribing daily walking with a cane or assistance was to help a lady with dyspnoea, unknown etiology, and no further workup would help. Dr. Dabney stated that she did not have dyspnoea for two days, and when she called she was having dizziness, she thought it might be the medication, and she was concerned mainly about falling. He told her that she needed to walk as he had told her many times. Dr. Connell said that the data in the file states that she was having trouble breathing. Dr. Dabney said he questioned her about her breathing, but she said she had not had that for over two days. Dr. Connell questioned if walking was enough for a 74-year-old lady with multiple comorbidities. Dr. Dabney said that he had spent a good amount of time examining her heart and did not feel she needed to be admitted to the hospital at that time. He told her if it continued to go to the emergency room or call him and they would work it up.

Dr. Connell questioned the Meclizine that was prescribed on July 27th. Dr. Dabney said he had prescribed it in the past for the Meniere's disease. The drug is an antihistamine and is used to treat vertigo. It can cause drowsiness. Dr. Connell stated in the Physician's Desk Reference (PDR) that one of the common side effects of Meclizine is dizziness. Dr. Dabney felt it would be more like light headedness rather than vertigo and didn't think it was a problem.

Tim B. Hunter, M.D. asked if in retrospect how Dr. Dabney would have done things differently. Dr. Dabney stated he would have admitted her into an intensive care unit himself and would have gone further in cardiac consultation. Dr. Dabney said he has four cardiologists. Many of the physicians do cardiology and can admit, and many times they also have cardiology consultation come in.

Lorraine Mackstaller, M.D. questioned why Dr. Dabney did not stop the Verapamil when S.G. had a documented left bundle branch block, a first-degree AV block, and a documented pulse of 50 that rechecked at 80. Dr. Dabney stated the patient had been on the drug for a long time and even though she had been stress echoed with a cardiologist, he felt at that time it was not causing further difficulty. Dr. Mackstaller referred to the note where he questioned heart block. Dr. Mackstaller was concerned that Dr. Dabney would not take S.G. off Verapamil when he knew it aggravates heart block and his note questioned first-degree heart block.

Mr. Giancola, counsel for Dr. Dabney, made a closing statement. S.G. did suffer a total heart black when she was admitted to the emergency room. Mr. Giancola referred to the report that Dr. Ellert, president of the medical staff at Maricopa Health System and chair of the Department of Family Practice, wrote. He noted that Dr. Ellert reviewed the chart carefully and presented the information, which was available to Dr. Dabney at the time the event took place, to five board certified family practice physicians. Not one of the five family practice physicians would have said that this needed to be referred to a cardiologist, that there were any problems with bradycardia or that there was concern about coronary artery disease. Dr. Ellert echoed these conclusions himself and felt based on the information Dr. Dabney had available to him, his treatment was entirely appropriate, particularly when he instructed the patient to go to the emergency room if symptoms persisted. Mr. Giancola asked the Board to not allow knowledge of the outcome to influence the determination of the propriety of the care that was available at the time the patient presented.

Dr. Connell stated that he felt Dr. Dabney's approach was over-casual for a patient who had been in his care for a long period of time. He felt Dr. Dabney came to the proper conclusion to consider complete heart block, but Dr. Connell does not feel Dr. Dabney took proper notice of the evidence in front of him. Even though S.G. was on Verapamil for a long time, disease of the conducting system is slow and progressive and can occur catastrophically, but often is progressive. The SIRC committee recommended a Letter of Reprimand and CME. Based on the information in the formal interview, Dr. Connell recommended an Advisory letter for improper management of the patient with symptomatic bradycardia.

MOTION: Dr. Connell moved to issue an Advisory letter for improper management of a patient with symptomatic bradycardia. There is insufficient evidence to support discipline.
SECONDED: Robert P. Goldfarb, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ronnie R. Cox, Ph.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine L. Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, Ph.D., R.N. The following Board Members abstained from this matter: Ingrid E. Haas, M.D.
VOTE: 11-yay, 00-nay, 01-abstain/recuse, 00-absent
MOTION PASSED

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	RESOLUTION
3.	MD-04-0639A	AMB V. FRANKLIN H. BAROI, M.D.	22605	Continue the investigation and issue an Interim order for a PACE evaluation, within 90 days, at the physician's expense, to determine his fund of knowledge in family practice, pharmacology, prescribing, and pain management.

Dr. Baroi was present with legal counsel, Mr. Gordon Bueler.

Dr. Sems, Medical Consultant, presented the case. This case was brought to the attention of the Arizona Medical Board on May 19th, 2004 by an anonymous complainant alleging Dr. Franklin Baroi excessively prescribed narcotics to multiple patients and failed to document appropriately. Dr. Baroi received notice regarding this as well as a subsequent notice about later allegations involving several other patients. The allegations included: excessive prescribing of narcotics and other controlled substances, failure to adequately treat

several disease states, failure to refer appropriately and failure to maintain adequate medical records, as well as others. The Board medical consultant opined that Dr. Baroi clearly over prescribed controlled substances to numerous patients and maintained poor medical records. The Staff Investigational Review Committee (SIRC) recommended that Dr. Baroi be issued a Decree of Censure for improper prescribing practices and inadequate recordkeeping and that he be required to take 20 CME hours in prescribing controlled substances and 10 hours CME in recordkeeping. The CME requirements should be over and above the CME for biannual license renewal.

Dr. Baroi made an opening statement. He practices in Casa Grande. There are no pain specialists in Casa Grande, which makes it very difficult for many patients to see a pain specialist. Therefore, the family practitioners and primary care physicians are often asked to manage patients' pain. Dr. Baroi stated that he is not a board certified pain specialist; he is a family practitioner and a hospice physician with a fairly good knowledge of pain management in various disease processes. He stated that physicians also manage a various amount of complex diseases, and being in a small town, it becomes almost impossible not to, because of the shortage of physicians in the area.

Patrick N. Connell, M.D. led the discussions and focused on several of the records the medical consultant had addressed in the report. He referred first to the handwritten notes on a preprinted form of patient J.W., and asked Dr. Baroi to identify the first medication listed. Dr. Baroi stated it was Claritin D12H. He could not identify the date the medication was started, or the refill amount. Claritin was crossed out and Dr. Baroi indicated that it was his standard at that time to cross out the medication when it was stopped. Dr. Connell questioned Dr. Baroi on the standard of care in family practice on record keeping for medication. Dr. Baroi agreed that the date the medication was started, the amount prescribed, the number of refills, and the date the medication was stopped should be recorded. Dr. Baroi admitted that his medical records regarding the prescribing of Claritin did not meet the standard. Dr. Connell questioned the next medication, OxyContin 240 milligrams, for the same patient. He asked Dr. Baroi to state what medication this was describing and he replied back Oxycodone. Through Dr. Connell's questioning it was determined that Dr. Baroi did not know when the prescription started, the number dispensed, or when it was discontinued.

Dr. Connell referred to medical record of 5/3/2004 that refers to a patient wanting a refill of medications. Dr. Connell asked Dr. Baroi to explain the situation. Dr. Baroi replied that the patient brought in a bottle which he had received medication in, in the past. It was half full of water with a powdery material in it. The patient explained that he didn't think he could get all the pills out of the bottle so he added water to the bottle so he could administer the medication properly. Dr. Baroi noticed the patient's thoughts were not appropriate and his explanation did not make sense. In the medical records under Objective, it stated the patient was 302 pounds, had a blood pressure of 186/100, a pulse of 120, was agitated and restless, and drank from the faucet repeatedly. Dr. Baroi thought the patient was overdosing on his medications. Dr. Connell noted Dr. Baroi's assessment of failed back syndrome, laminectomies, pain, diabetes, and insomnia. The assessment showed no reference to drug abuse or overdosing. Dr. Baroi agreed that he should have added that to the assessment. Dr. Connell asked if this met the standard of care. Dr. Baroi felt that it did because he addressed it later on in the plan. In the plan, Dr. Baroi described speaking to the patient at great lengths. He's known the patient for 10 years and has seen him through many crises. He told the patient that their relationship was a working relationship as physician to patient and that he cannot fail to comply with the medication regiment prescribed. Dr. Baroi told the patient that he could no longer manage his pain for him and he should be referred to a pain specialist. He told the patient that he had lost all control of the amount of medication he was taking. Dr. Connell asked if was appropriate to give a toxic patient a prescription of 200 Methadone to a patient who was assessed as overdosing on medication. Dr. Baroi said that with reluctance, but he did it because the patient was discharged from his care and allowed him 200 more until he could find a pain specialist. Dr. Connell asked if Dr. Baroi felt his evaluation and treatment of J.W. corresponds to the Arizona Medical Board guidelines on prescribing of controlled substances. Dr. Baroi was familiar with these guidelines and felt he had met the standard of care. Dr. Connell asked if Dr. Baroi had a pain contract with J.W, to which he replied "no". Dr. Connell asked if a urine drug screen was ever done to see if the patient was taking the medications he prescribed. Dr. Baroi said he had not done any tests. Dr. Baroi agreed it would have been useful to do a drug screen for this patient.

Dr. Connell reviewed the list of medications J.W. was taking and asked Dr. Baroi to describe the type of medication each was. Dr. Baroi replied that Sular was used for hypertension and is a calcium channel blocker to lower the vascular tone. Elavil was used for his insomnia. It is a tricyclic medication that is difficult to manage in an overdose. Dr. Baroi admitted that it was not a safe drug for a drug addict or someone with erratic behavior, but in comparison to other medications it can be safer. Dr. Connell asked what types of drugs would be safer. Dr. Baroi said benzodiazepines or tonazaphen. Dr. Connell asked why they were safer in this case. Dr. Baroi said having known the patient he did not want to increase the number of medications J.W. would be further addicted to. J.W. was taking Percocet was used to treat the severe lower back pain the patient had from two lumbar laminectomies. The pain specialist recommended he be on two pain medications. Dr. Baroi agreed to refill what the pain specialist recommended. Dr. Connell asked to see a copy of the consultation record. Dr. Baroi did have one from 2002, but it did not appear to be with the Board records. Dr. Connell asked if it was common for a pain specialist to prescribe short-acting opiates on a long-term basis for treatment of chronic non-malignant pain. Dr. Baroi said it could be as long as it is coupled with a long acting medication like Methadone. This patient was receiving both. Dr. Baroi prescribed 200 doses of methadone at strength of 10 mg on the same visit, but it was not recorded.

Dr. Connell asked about Diovan. Dr. Baroi responded that it is commonly used for hypertension and is in a class of drugs called ARBs. Dr. Connell asked about Dilantin. The patient had a seizure postoperatively after his injuries. He's been on Dilantin for a long time. Dr. Connell did not see a reference to the seizure disorder in the records and asked if Dr. Baroi had addressed when the last seizure was. Dr. Baroi had not and admitted it would be important information to know. Dr. Baroi did not remember ordering a Dilantin level. Dr. Connell inquired about a record of consultation from a neurologist and Dr. Baroi said he did not have one. Dr. Connell asked for confirmation that J.W. was taking 240 mg of OxyContin three times a day and Percocet and Methadone. Dr. Baroi said he was not because he could not afford OxyContin. Dr. Connell asked if that was documented so that another treating physician would know the thought process. Dr. Baroi stated no. Dr. Connell questioned the standard of care for maintaining records in the event that Dr. Baroi went on vacation. Would another physician be able to look at the chart and have a reasonable idea of what the thought process was?

Dr. Baroi stated if he went through the entire chart it would be possible. Dr. Connell asked if it would be reasonable to have a medication list so that someone could look at it at a glance. Dr. Baroi felt it would be reasonable. Dr. Connell questioned the prescribing of Ritalin. Dr. Baroi said the pain specialist had prescribed it for the patient and Dr. Baroi continued to prescribe it for J.W. The medication was for ADHD and is a class 2 drug used does not fully understand how Ritalin works, but it is used to treat ADHD in children. He stated that a contraindication would be cardiac arrhythmia or cardiac problems. Dr. Baroi did not have this documented but having known the patient believed the patient did have ADHD. Dr. Connell asked if Ritalin was a good choice for a patient with seizure disorders, blood pressure of 186/100, or a heart rate of 120. Dr. Baroi stated it would not be the best choice.

Dr. Connell stated that he had three or four pages of notes documenting Dr. Baroi's prescribing practices, but felt that they would only reveal the same answers as Dr. Baroi already provided the Board. Based on what he has read and what he has seen in the interview Dr. Connell had concerns about the doctor's basic fund of knowledge in the area of pharmacology. Dr. Connell recommended continuing the investigation and referring the doctor for a PACE evaluation to determine his basic fund of knowledge in pharmacology and family practice.

Dr. Krishna asked if due process was needed to get the physician's response and the attorney's response before continuing with the motion. Ms. Cassetta stated that if the investigation is being continued, the physician and attorney would have an opportunity to appear again before the Board. Ms. Cassetta noted it was within the Board's power to issue an Interim Order and there were no due process issues.

MOTION: Ram R. Krishna, M.D moved to continue the investigation and issue an Interim order for a PACE evaluation, within 90 days, at the physician's expense, to determine his fund of knowledge in family practice, pharmacology, prescribing, and pain management.
SECONDED: Lorraine Mackstaller, M.D.

Dr. Megdal stated that she is in support of the motion, but requested clarification as to what Dr. Baroi is being evaluated on. Dr. Connell said the PACE evaluation would provide an overview of Dr. Baroi's basic fund of knowledge of pain management and pharmacology. Dr. Hunter thought these overlapped greatly and thought family practice would probably be inclusive of the others. Dr. Connell felt if a letter was sent to PACE saying the overall concern is fund of knowledge and family practice, but primarily in areas of prescribing pharmacology, they would tend to focus in that area.

Ms. Cassetta said that Staff confirmed PACE would offer exactly that.

VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	RESOLUTION
4.	MD-04-1192A	B.S. V. JAMES R. BOYED, M.D.	13616	Advisory letter for inadequate evaluation of a patient with hematuria, this case does not rise to the level of discipline.

Dr. Goldfarb stated that he knows Mr. Slutes through legal work for his medical corporation, but it would not influence his ability to adjudicate this case.

James R. Boyed, M.D. was present with legal counsel, Mr. Slutes.

Dr. Huber presented the case. The patient in this case is a 29-year-old man who alleged that Dr. Boyed improperly and inadequately assessed his urinary symptoms, treated him improperly, and failed to make the proper diagnosis. The man had started a vigorous exercise program and was about two days into it when he noticed that his urine was a dark brown color. He reported this to Dr. Boyed's office. The patient came in and was promptly seen by a medical assistant. A dipstick urinalysis was done. A urinary infection was diagnosed and he was started on an antibiotic. Apparently the urinalysis was led astray and a diagnosis of rhabdomyolysis was missed. The medical consultant who reviewed this case felt that the allegations were supported and that the evaluation was inadequate and improper. Additionally, Dr. Boyed added in his reply to the Board, that he didn't see any findings or symptoms that were suggestive of rhabdomyolysis. This implies to me that he simply was not acquainted with the condition.

Dr. Boyed made his opening statement. He received a call in the morning from B.S. saying he had two days of vigorous exercise, he had noticed a change in his urine, but there were no other symptoms other than mild frequency. Dr. Boyed requested the patient come in with his concern that he did have rhabdomyolysis. When he reviewed the urine, there was the positive dipstick. Dr. Boyed does his own microscopy in the office. When he reviewed the urine, there were red blood cells, and there were no cast cells. Given the patient's lack of symptomatology, and the fact that having the red blood cells, it was an encouraging sign that he did not have rhabdomyolysis. Dr. Boyed was left to believe that his working diagnosis at that point in time was that B.S. had passed a stone, had early prostatitis, or had some sort of trauma from some other bladder anomaly. The urine was sent for a CNS, Dr. Boyed set him up for an IVP; made sure he was drinking plenty of fluids, and started him on ciprofloxacin. He asked the patient to call if there were any other symptomatology. Dr. Boyed never head anything more from that. He learned in October that this patient was hospitalized for rhabdomyolysis. At that point in time it became clear Dr. Boyed had committed a cognitive error. He did not believe that this gentleman had rhabdomyolysis when he came in for the office visit. Dr. Boyed stated that he had made diagnoses of rhabdomyolysis the past, under considerations similar to this, for three or four other cases. He hospitalizes and takes care of his patients in that situation.

Dr. Boyed stated that after careful review of the case, he felt there was several issues that contributed to the error: 1) he did not examine the patient, and 2) the month before he had initiated an open access schedule to provide better access to him and to minimize complaints from HMOs that he was not sending patients to the emergency room and urgent care. Dr. Boyed stated that on that

particular day it was not working well with his attempt at an open access process. He had a full schedule and they were still using the traditional schedule. He also had two other emergencies that day that required hospitalization. He had to determine who was the sickest of his patients. Since there were no other major symptoms, he felt that checking the urine was going to be enough to make an adequate diagnosis, which, unfortunately turned out not to be. Dr. Boyed admitted that on that day he was over his head with the number of patients and did not properly see his patients. Dr. Boyed felt he would have had a better chance at making the proper diagnosis. Dr. Boyed has since initiated some corrective measures so that a situation like this will not occur again. He no longer provides an open access schedule process. He is eliminating a two-payer group from his practice to minimize the overwhelming situation and the situation that occurred, and he is not taking new patients for the next six months. Dr. Boyed feels his proposed measure will help him to continue as a good-serving physician to the people, and hopefully minimize any further cognitive errors.

Dr. Connell led the questioning by referring to the September 15, 2004 dictated note that described the history. Dr. Boyed said the note was obtained from the triage nurse who had been a medical assistant for 15 years. He confirmed that he did not talk to the patient on that day. Dr. Connell and Dr. Boyed reviewed the events of the day. Dr. Connell asked how common urine infections were in 29-year-old males. Dr. Boyed said urinary infections are not common, but he has seen it happens with bike riders where they get inflammation and secondary infections. Dr. Boyed stated the patient had started an aerobic program his company started. Dr. Connell asked if the diagnosis is different for a male than for a female. Dr. Boyed said that it is different and feels he might have gone in a different direction if he had actually seen the patient. Dr. Connell asked about the coloring of blood after passing a stone. Dr. Boyed stated a patient could have a significant amount of hematuria. Dr. Connell asked if other symptoms would be present. Dr. Boyed stated yes if he did have that, but in this case the history was not complete because he had not seen the patient, everything was based on the information obtained from the triage. Dr. Boyed agreed that this is not a standard that he would adhere to at this point in time. Dr. Connell asked Dr. Boyed to explain his thinking process with obtaining an IVP. Dr. Boyed stated an IVP would show the consideration of some other trauma obtained from his exercise, some sort of urakal anomaly, diverticulum, polyp, any of those things that from exercise can cause a significant hematuria. Dr. Connell asked if it is possible that a renal cell carcinoma could cause painless hematuria. Dr. Boyed said that it is possible. Dr. Connell asked if Dr. Boyed considered a CT scan versus an IVP. Dr. Boyed stated that it was a consideration however he felt it would be quicker to obtain the IVP without having to go through the insurance companies to get the okay.

Ram R. Krishna, M.D. asked if Dr. Boyed was concerned about someone coming in with hematuria, prescribing an antibiotic without knowing the problem, that he might be covering up something that is dormant like a tumor or passing a stone. Dr. Boyed stated yes it is a concern, which is why he obtained the IVP. Dr. Krishna questioned how the doctor could put him on antibiotics without knowing the diagnosis. Dr. Boyed said that it is something that is done often when there is a possibility of a differential diagnosis. Dr. Krishna questioned the patient not being examined before prescribing antibiotics and Dr. Boyed referred back to his previous explanation that it is not his normal standard of care, but on that day with all the office problems he was trying to help those who appeared to be the sickest.

Dr. Connell felt the doctor had been candid and described accurately what happened and what the errors were. He felt the doctor has taken measures to ascertain that it will not occur again. Based on that Dr. Connell recommended issuing an advisory letter.

MOTION: Dr. Connell moved to issue an Advisory letter for inadequate evaluation of a patient with hematuria. This case does not rise to the level of discipline.
SECONDED: Ram R. Krishna, M.D.

Douglas D. Lee, M.D. commented that in 2001 an advisory letter was issued to the doctor for misdiagnosis of a right lower abdominal pain based on a consultation with a nurse practitioner. He stated that it is not exactly the same, but there is a history of this.

Sharon B. Megdal, Ph.D. responded that the mitigating factor is the change in the practice setting and a record is being created so the next time, and hopefully there won't be a next time, it could rise to a level of discipline.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Lorraine L. Mackstaller, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, Ph.D., R.N.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED

CALL TO THE PUBLIC – 1:15 p.m.

Statements issued during the call to the public appear beneath the case referenced.

FORMAL HEARING MATTERS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	RESOLUTION
1.	MD-05-0164A	AMB V. KENLEY MOSHE REMEN, M.D.	30159	Adopt the Finding of Facts, Conclusion of Law and Order, with typographical corrections.

D.R. spoke at the Call to the Public. D.R. is Dr. Remen's father. D.R. stated that ten months ago he noticed acute changes in Dr. Remen. He stated that he was not functioning and has lost some touch with reality. He needed evaluation and psychiatric help at the hospital. The family is greatly saddened by the tragedy and suffers with him. D.R. has never seen Dr. Remen take illegal drugs or have a drug problem. D.R. stated that Dr. Remen is into natural medicine is reluctant to put unnecessary drugs into his body.

P.R. spoke at the Call to the Public. P.R. is Dr. Remen's mother. She explained that there was a procedural misunderstanding at the law judge hearing and Dr. Remen was not represented. She was under the impression she would be able to talk and was not allowed that opportunity. Dr. Remen had no defense. The public interest in this case is served with a suspension, and she understands that it needs to be this way. She didn't feel the license should be revoked. Dr. Remen has mental health problems at the moment and feels a suspension would give him the ability to get better. He is unable to face the Board due to his recuperation. P.R. read the positive characteristics of Dr. Remen and feels he will make a great doctor. Dr. Remen was rated in the top 10% of his evaluators and received honors in everything. P.R. read a letter from Dr. James Feld, chief at the hospital, who praised Dr. Remen.

Stephen Wolf, Assistant Attorney General, presented the case. He noted for the record that he did not prevent the parents from speaking during the hearing. The hearing transcript shows that Dr. Remen did not authorize release of this information to his parents. When that was brought to the Administrative Law Judge's (ALJ's) attention he decided to excuse Mrs. Remen from the discussion. Mrs. Remen asked to make remarks, the judge listened briefly and stated family members do not have legal standing. It is either the legal representative or the licensee himself that can appear.

Mr. Wolf addressed a statement made in the call to the public that Dr. Remen had not engaged in the use of illegal substances. He stated that Dr. Remen admitted during the evaluation that he had used marijuana and other hallucinogenic drugs. On the basis of that information Mr. Wolf asked the ALJ to consider ordering an evaluation for substance abuse. This was consistent with some of the manifestations of his illness at that time. Mr. Wolf is in full agreement with the ALJ's recommended order. Dr. Remen had been non-compliant with his court ordered treatment. He left the country and was residing in Israel at the time of the formal hearing. He still has not appeared for these Board proceedings. Mr. Wolf felt the Board should obtain an evaluation of his mental status and recommend any treatment based on the findings. Mr. Wolf recommended that Dr. Remen be given one year to comply with the Order and if he refuses the stay would be lifted and his license revoked. If he complies with the order for evaluation and treatment then the stay would remain in place for as long as he is compliant. If he returns to a condition where he is safe to practice medicine then the stay and suspension would be lifted.

Christine Cassetta stated that formal hearings conducted at the Office of Administrative Hearings are open to the public, but if there are confidential or sealed documents the ALJ can ask that the public leave the room.

Sharon B. Megdal, Ph.D. asked about where Dr. Remen is currently residing. Mr. Wolf replied that he did provide a new residence, but there is still a business address listed in his profile where mail can be sent.

Ms. Cassetta stated that she made some grammatical and typographical changes to the ALJ's recommended decision.

MOTION: Ram R. Krishna, M.D. moved to adopt the findings of facts, conclusions of law and order, including the typographical corrections.
SECONDED: Ronnie R. Cox, Ph.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Lorraine L. Mackstaller, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, Ph.D., R.N.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED

2.	MD-04-L231A	AMB	IBRAHIM H. LOTFY, M.D.	N/A	Adopt the Finding of Facts, Conclusion of Law and Order.

Stephen Wolf, Assistant Attorney General, informed the Board that the State recommended adopting the ALJ's Finding of Facts, Conclusions of Law and Order in it's entirety that support a recommended order for denial of license.

Dr. Lofty was present without legal counsel. Dr. Lofty stated that he disapproves of the ALJ findings because the ALJ felt he was misleading because he failed to check a question on his license application and it was alleged that Dr. Lofty purposely left it unchecked. Staff has admitted that when a box is not checked the normal procedure is to send a letter saying something was not checked. This never occurred. The application took 14 months to investigate which was out of Dr. Lofty's hands. The case against him was dropped a year prior to any Board decision. Dr. Lofty presented a sworn testimony from an attorney, which proved the judge had decided the program Dr. Lofty he entered was a mistake. Dr. Lofty provided a document that supported the judge's statement. Dr. Lofty said at the time of the decision, the case was dropped and there was nothing to hide. He simply overlooked a question. The question asked if he had an investigation by any board and if he had ever been convicted of a crime. At the time of the application the case had been dropped so he was not under investigation by a board, and he has never been convicted of a crime. Dr. Lofty stated that he left his residency because of an incident that had happened in 2002. He provided a sworn testimony, an agreement from the college saying he withdrew from the program, and provided two letters about the incident. He didn't hide anything. Dr. Lofty said the way the application is written is misleading.

Mr. Wolf stated that these were the same arguments that were presented to the ALJ and they were not supported.

Sharon B. Megdal, Ph.D. asked if the Attorney General's office had issues with the form of the order as presented. Mr. Wolf stated that he normally looks at the substance of the ALJ's decision to determine that it is factually correct. Dr. Hunter also found the form to be unusual. Ms. Cassetta stated the ALJ decision was not drafted in a normal format. Under statute the ALJ is required to submit findings, conclusions and order. Ms. Cassetta did not feel it met those requirements. Dr. Megdal felt that there were extraneous sections, but felt that it had findings of fact, conclusions of law, and an order.

Tim B. Hunter, M.D., asked if the form was reasonable and would there be problems if it were appealed. Ms. Cassetta noted the form in this case would not be appeal issue, but deferred to the litigator on that issue. Ms. Cassetta noted her concern that there may be a case in the future where the form used in this case does present a problem. Mr. Wolf did not see a problem if this Order were appealed.

MOTION: Patrick N. Connell, M.D. moved to adopt the Findings of Facts, Conclusions of Law and Order as written by the Administrative Law Judge.
SECOND: Ronnie R. Cox, Ph.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Lorraine L. Mackstaller, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, Ph.D., R.N.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED

William R. Martin, III, M.D. asked how the Board could communicate its issues with the form in which the ALJ's decision was presented. Dr. Hunter requested the Executive Director write a letter to the Office of Administrative Hearings and request that future orders be drafted in the standard format.

The meeting concluded at 7:16 p.m.

THURSDAY, AUGUST 11, 2005

CALL TO ORDER
Tim B. Hunter, M.D., Chair, called the meeting to order at 8:00 a.m.

ROLL CALL
The following Board Members were present: Tim B. Hunter, M.D., William R. Martin III, M.D., Douglas D. Lee, M.D., Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Becky Jordan, Ram R. Krishna, M.D., Dona Pardo, Ph.D., R.N. Ronnie R. Cox, Ph.D., Ingrid E. Haas, M.D., Lorraine L. Mackstaller, M.D. and Sharon B. Megdal, Ph.D.

CALL TO THE PUBLIC
Statements issued during the call to the public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-04-0493B	AMB	JUSTIN WEISS, M.D.	9418	Letter of Reprimand for failure to properly interpret radiologic studies resulting in a delayed diagnosis of breast cancer.

Tim B. Hunter, M.D., recused himself from this case.
Robert P. Goldfarb, M.D., recused himself from this case.

Justin Weiss, M.D. was present with legal counsel, Mr. Tom Slutes.

Roderic Huber, M.D. presented the case. An outside radiologist consultant reviewed the case. The Board was informed in April 2004 of a malpractice settlement from a 67-year-old woman who alleged Dr. Weiss negligently interpreted multiple mammograms and other breast related studies. The proposed standard of care was that the primary physician should examine the patient, confirm any palpable masses, and then imaging studies should be done as appropriate. The consultant concluded that Dr. Weiss had deviated form the standard of care. There were findings that were not reported. The studies obtained were always screenings rather than diagnostic. The Medical Consultant determined that at least one ultrasound was suboptimal. The Medical Consultant felt the allegation was supported.

Dr. Weiss referred to the July 28th letter from his attorney and stated that he had served the El Rio Community Health Center for over 20 years without incident doing mammography examinations. El Rio serves underinsured and uninsured patient population and has served since 1985 without any incidents in mammography examinations.

Ingrid E. Haas, M.D. questioned Dr. Weiss on the initial visit in March 1998. Dr. Weiss verified the patient was initially referred in the summer of 1998. The tests were ordered as a mammogram without specification. Dr. Weiss stated that the technologist normally makes the decision as to which type of testing is done, whether it's screening or diagnostic. In this case, the technologist decided to do a screening mammogram. Dr. Weiss felt in hindsight it probably was not the best test to do. Dr. Haas felt a diagnostic exam would have been the standard.

Dr. Haas questioned Dr. Weiss on the review of the tests. Dr. Weiss stated the tests were delivered to his private office. Dr. Weiss read the patient's history from the primary physician before he reviewed the films. When he read the films he felt they were normal and he noted a disclaimer in the records that the patient had very dense breasts. He felt the doctor would know what the disclaimer meant. An August 1998 mammogram test was done and diagnosed as negative. Dr. Weiss stated that 2-3% of negative mammograms are actually abnormalities. He said this test result fell into a category of probably benign/probably normal and he recommended follow-up in

six months. Dr. Haas said that another mammogram was done in November 1998 and spot compressions and synography were done. Dr. Weiss put another disclaimer on the test that "further evaluation should not be dissuaded". Dr. Haas said the patient followed up with her physician in May 1999 with a questionable slight distortion of the left breast. She noted that the patient had been back three times in less than a year. Dr. Haas asked Dr. Weiss to describe what he saw in the third film. Dr. Weiss thought he had seen some distortions in the left breast and recommended spot compression. When Dr. Weiss reviewed the spot compression tests in June 1999, he saw compressing and did not see distortion and felt that it was most likely benign and recommended a 6-month follow up. The outside Medical Consultant felt these tests were inadequate. Dr. Haas asked what Dr. Weiss would have done if he had also felt the tests were inadequate. Dr. Weiss replied that in retrospect, he would have asked the patient to return. Dr. Weiss has changed his policy now and does not accept a unilateral spot compression.

Dr. Haas discussed the December 1999 visit where the patient returned for the 6-month evaluation. In the patient's history she still expresses concern of the mass she has felt for over a year. Dr. Haas asked Dr. Weiss to explain what he saw in the tests. Dr. Weiss stated that he did not receive the patient's chart in December 1999. He had commented there were stable appearances of the left breast. Dr. Weiss saw a distortion that was a concern, but determined them to be asymmetric fibro tissue. The radiologist noted that he did not see any mass or abnormality on the left breast. Dr. Haas reviewed the physician's records that noted the patient's continued concerns with the mass. In August 2000, a different center took films and noted a 2-3 cm mass. Dr. Haas noted that the patient had been evaluated for two years. Dr. Haas asked if those findings would indicate an advanced case of malignancy. Dr. Weiss agreed that it was an indication of advanced or aggressive malignancy. Dr. Haas replied that it was poorly differentiated so it could have been either. She was surprised that it took two years to find it.

Lorraine Mackstaller, M.D. asked who would be responsible for determining how an ultrasound compression would be done for a suspicious mass. Dr. Weiss stated in Breast Centers where there is a full-time radiologist on site, it is routine for the radiologist to be present and confirm the findings that are being scanned. He stated that at El Rio it is up to the technician to decide how and where to look at the area in question. Dr. Mackstaller noted that the last mammogram request did not have history on it but many other requests described the mass in the left breast, and one of the notes actually described skin retraction. Dr. Mackstaller questioned Dr. Weiss on the history that was available to him. Dr. Weiss indicated he had history available on the order forms, but it did not say, "skin retraction", it said "attention 12:00 to 2:00 position." He indicated that there was a history of the breast lump, and a history of when the spot compression views and sonogram were performed. Dr. Weiss stated that at that time he requested a follow-up mammogram. He also noted questionable distortion in one of the studies, which indicated a red flag. Dr. Weiss added that if spot compression views are done and are of good quality and the area does compress, it is most likely benign. It's not 100% perfect modality, and that's why, the clinical findings of anything that might be palpable should supersede the mammogram.

Dr. Haas reviewed the August 2000 and December 1999 films and noted an ink mark on the December 1999 compression. Dr. Weiss did not recall if he made the ink mark or if it had occurred in litigation. Dr. Weiss reviewed the films and stated that he had been trained that that lymph nodes are not a reliable indicator of significant breast disease. He stated that there are too many variables of lymph nodes enlarging and it is too common to comment on by itself. Dr. Haas noted the situation with the patient having frequent evaluations where both the patient and the physician were concerned. She asked Dr. Weiss if this would be something that he would look into, to provide more information as to what is going on. Dr. Weiss replied in retrospect, with the history and the lymph nodes, he would have been more tuned into it. He felt that if he commented all positive lymph nodes greater than a centimeter and a half in a symptomatic patient his false positive rate would skyrocket. He felt that would defeat the purpose of having a mammogram.

Dr. Haas asked how the equipment has changed since 1998. Dr. Weiss replied that El Rio purchased new equipment. Dr. Weiss changed the protocol and no longer allows the technician to perform diagnostic mammograms without his being present. He also gave notice to El Rio Health center that he will no longer be performing mammography after September 1st. Dr. Weiss explained that his reasoning behind giving his notice to El Rio was related to the medical and legal aspects of breast imaging in private medicine. There are issues related to something that may be obvious or may be easy to detect in retrospect, but is difficult to discern when performing a large volume mammography. Dr. Weiss advocated with El Rio to contract with a dedicated women's imaging specialist to do mammography.

Dr. Mackstaller asked about adenopathy. Dr. Weiss stated that adenopathy can be the only presentation for a patient with breast cancer which is detectible either by palpation or by mammography in terms of breast mass. The American College of Radiology has revised the classification four times in the last several years, and none of the revisions have a site for mammography in terms of describing lymph nodes. Every other pertinent or positive finding from a checklist is there for the radiologist to describe. Dr. Weiss believes that the reason for that is that lymph nodes in and of themselves are not reliable indicators of significant pathology in terms of breast cancer. Dr. Mackstaller asked Dr. Weiss if, based on the history of having a palpable left breast mass and finding the adenopathy, it would trigger a biopsy or more intense workup than just repeating a mammogram in six months. Dr. Weiss stated it would from a clinical standpoint. But from a radiologist standpoint, radiologists can make recommendations based on the mammogram alone. It would not warrant a radiologist recommending a biopsy. In retrospect he would have recommended this.

Ram R. Krishna, M.D. asked what the standard of care was in 1999 for a mammogram. Dr. Weiss stated that he was not expected to examine a patient in 1999. He confirmed that he could have discussed with the referring physician doing a diagnostic instead of a screening. Dr. Weiss said that there is not a uniform standard for converting from a screening to a diagnostic study because the definition of what compromises a diagnostic study varies. Dr. Weiss stated that in 1999 he did have the privilege of bringing a patient back for further studies if he had concerns. Dr. Krishna asked if Dr. Weiss would have done things differently looking back. Dr. Weiss replied that he would have been more aggressive at the time and communicated more aggressively with the primary care doctor.

Ronnie R. Cox, Ph.D. noted earlier that Dr. Weiss had presented some budgetary concerns about El Rio and asked how he had learned about them. Dr. Weiss replied clarified that El Rio had limited resources and wished to provide the largest amount of diagnostic

imaging that they could in terms of patient care. He stated that El Rio has always had limited resources for mammography because they serve a lot of patients who do not have insurance.

Dr. Haas asked Dr. Weiss about recently CME courses he took. Dr. Weiss attended courses in April 2005 on the latest developments of mammography and screening. The course was 16 hours and covered computer-assisted detection, MRI for patients with dense breasts, using tele-mammography with digital mammography, and covered ultrasounds.

William R. Martin, III, M.D. followed-up with additional questions on screening versus diagnostic and who is responsible for the decision. Dr. Weiss responded in two parts: 1) The person who determines whether to do a screen or diagnostic study generally is the primary ordering physician, the physician assistant, or the nurse practitioner. A patient can also come in for a screening study without a referral. 2) If a study is abnormal or suspicious the study can be converted to a diagnostic mammogram to provide additional views, magnification of views, or spot compression views. Dr. Weiss indicated that the radiologist or a well-trained mammography technician could determine the views. In summary, Dr. Weiss stated everyone could be responsible for making a wrong study with bad patient outcome including the radiologist.

Dr. Cox asked Dr. Weiss to list other social organizations that he has contracts with. Dr. Weiss contracted with Indian Health Services, in his private practice he contracted with St. Elizabeth of Hungry, and El Rio Health Services. He closed his private practice in 2002. His business relationship in the private practice was to do the patient studies that could not be done in house. He agreed not to refuse patients, and/or to provide very discounted rates or cost rates. Dr. Cox stated that earlier Dr. Weiss' indicated his peers criticized him for his rates. Dr. Weiss denied saying this.

Ram R. Krishna, M.D. wanted to clarify for the record that El Rio, and any other organizations like them, are not in the red. They get enough funds to pay for services. He stated that care should not be anything less than what anyone would get elsewhere. Dr. Krishna noted that he sits on a similar organization Board in Yuma run by El Rio. Dr. Krishna stated El Rio is always in the black and providing services and it should not be taken into account that Dr. Weiss was unable to provide proper care at that time. Dr. Krishna clarified that Dr. Weiss was giving subsidized rates and discounted rates for readings. That was an understanding between him and the organization he contracted with. The organization itself was not providing substandard care or at least they should not have been if they were. Dr. Weiss agreed with this statement.

In closing, Dr. Weiss clarified that two dedicated board certified radiologists (whom he has not talked to in 20 years) from dedicated women's imaging centers reviewed his studies and both concurred with Dr. Weiss in their report dated August 1st 2000. Dr. Weiss believes both radiologists exclusively do mammography and have no vested interest in the outcome. Both radiologists compared the films and indicated the mass in the latest film was new. Dr. Weiss stated these radiologists are in the same urban area in the same community that he practices in. They have no reason to whitewash his reports. He stated that an expert witness looking at the films who already knows the outcome of a patient is a much easier mammography to see in retrospect. Dr. Weiss requests that the Board allow him to be judged by his peers in the community who believe that the standard of care was met.

Dr. Haas summarized that there were various factors being looked at 1) the interpretation of the mammogram. Dr. Haas found it disturbing that the patient initially presented a complaint of breast mass in 1998. The patient was referred and evaluated, x-rays were done, ultrasounds were done, and various other things were done. The patient was never examined in the primary care center. Dr. Haas stated that if it is known that the patient has a breast mass, the radiologist evaluations are important, and they should give the patient feedback. Dr. Haas noted that Dr. Weiss testified that 2-3% of mammograms would be normal when there is actually something going on. 2) Primary care physician's interaction. If the physician as a radiologist had responsibility of the patient, and a mass was noted, more detailed evaluations would have been appropriate. It should not have been left up to the technologists. If the request said, "breast mass" and the films were done in a screening manner, then further evaluation should have been done. This is the responsibility of the radiologist. Dr. Haas was bothered by the fact that the patient complained of breast mass for two years and then received a diagnosis of breast cancer at a very advanced state.

MOTION: Ingrid E. Haas, M.D. moved for a finding of unprofessional conduct under A.R.S. §32-1401(27)(q) – Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECOND: Ram R. Krishna, M.D.
VOTE: 10-yay, 0-nay, 2-abstain/recuse, 0-absent
MOTION PASSED

Dr. Haas indicated the facility has the ability to get the necessary studies done and is doing the proper work and was not under funded. Dr. Haas determined after looking at the films and reviewing the outside medical consultant evaluation that the mass was present. She felt it was a failure to diagnose which leads to a letter of reprimand.

MOTION: Ingrid E. Haas, M.D. moved to issue a letter of reprimand for failure to properly interpret radiologic studies resulting in a delayed diagnosis of breast cancer.
SECOND: Ram R. Krishna, M.D.

Sharon B. Megdal, Ph.D. asked for clarification on continuing education. Dr. Haas replied that the Staff Investigation Review Committee (SIRC) recommended one-year probation with 20 hours of continued medical education (CME). Dr. Haas felt the doctor had demonstrated that he recently took 16 hours of education focused on mammography evaluation and changed his procedures in approaching the mammograms and diagnostic evaluations. Dr. Haas felt it was not necessary to include additional CME.

ROLL CALL VOTE was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Ingrid E. Haas, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Lorraine L. Mackstaller, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, Ph.D., R.N. The following Board Members abstained from the motion: Robert P. Goldfarb, M.D. and Tim B. Hunter, M.D.
VOTE: 10-yay, 0-nay, 2-abstain/recuse, 0-absent
MOTION PASSED

2.	MD-04-0769A	N.D.	STUART D. LANSON, M.D.	7318	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for misdiagnosis of vasculitis in part on unconventional therapy.

Ingrid E. Haas, M.D. stated that she is acquainted with Dr. Lanson, but it will not affect her ability to adjudicate the case.

Dr. Lanson was present with legal counsel, Mr. Paul Giancola.

Mark Nanney, M.D., Chief Medical Consultant, presented the case. He stated that the patient, N.D., is a 60-year old female with multiple complaints. Dr. Lanson diagnosed her with immune dysregulation and recommended oxygen therapy and immunotherapy. A Board medical consultant reviewed the file and found the diagnosis to be below standard of care for an allopathic physician because he did not order a sedimentation rate, urinalysis or tissue biopsy, which are conventional work ups for vasculitis. The medical consultant noted that the patient's lab values were normal and found that the patient did not have vasculitis and did not have an adequate work up.

Dr. Lanson underwent a peer review by the American Academy of Environmental Physicians, including a chart review, and was endorsed by the organization as his diagnosis and treatment is consistent with their standards. Dr. Nanney also informed the Board that this case was referred to the Homeopathy Board as well, but the board declined jurisdiction.

Dr. Lanson made an opening statement to the Board. He recited his credentials, including allopathic practice in otolaryngology for 20 years and environmental medicine for the last 13 years. He is board certified in ear, nose and throat from the American Board of Otolaryngology and he is fellowship trained in environmental medicine through the American Board of Environmental Medicine. Dr. Lanson then stated in regard to this patient, his work-up consisted of a detailed history with collaborative physical findings. His diagnosis was based on information from a textbook in environmental medicine on small vessel vasculitis. Dr. Lanson provided the Board with articles on environmentally triggered vasculitis. He also explained how vasculitis presents and how it related to the patient's underlying pathology. Dr. Lanson further explained that oxygen and intravenous nutrient therapy are accepted modalities recognized by the American Academy of Environmental Medicine. In his opinion, Dr. Lanson stated that the diagnostic work up and treatment plan were based on standards of care in his specialty. The diagnosis was well supported, but treatment was never carried out.

Patrick N. Connell, M.D. began the questioning by asking Dr. Lanson about his current practice. Dr. Lanson stated that he currently practices environmental medicine and sees on average about 30 new patients a month and about 30-40 patients a week. Dr. Lanson stated that other patients refer most of his patients and other physicians refer approximately 20 percent. Of those patients, only a small number, 1-2 percent, present with vasculitis. Dr. Connell questioned if the American Board of Medical Specialties (ABMS) recognizes the American Board of Environmental Medicine, through which Dr. Lanson is certified. Dr. Lanson replied that it is not a recognized board. Dr. Connell asked if Dr. Lanson considers himself as an expert in the area of vasculitis. Dr. Lanson stated that while he does not consider himself to be an expert, he recognizes the seriousness of the condition and understands that it is life threatening. Dr. Lanson described vasculitis in general by stating that it involved large vessels, medium sized vessels and small vessels, regardless of whether there was necrosis or not. In environmental medicine, Dr. Lanson stated that physicians who see vasculitis realize that many of the small vessels they see are non-immune mediated. This type of vasculitis is usually related to chemical exposure. Dr. Connell then asked Dr. Lanson to describe vasculitis as it would be described in a standard textbook. Dr. Lanson described spontaneous bruising, purpura, and decreased circulation and impaired functioning to various organ systems.

Dr. Connell then questioned whether Dr. Lanson did a sedimentation rate in this patient. Dr. Lanson admitted that he did not do a sedimentation rate, but agreed that it is a standard marker for vasculitis. Dr. Lanson added that if he had seen the patient in follow up he would have eventually ordered the sedimentation rate, but he did not have that opportunity with this patient. Dr. Connell questioned whether urinalysis or biopsy would have been useful. Dr. Lanson stated that ordering both studies would have been within the standard of care, but he did not order them. Dr. Lanson stated that the patient had an abnormal membrane capacity and described the possible causes for an abnormal measurement. He added that because he only saw the patient on two occasions, he did not have the opportunity to evaluate her for other possible causes. Dr. Connell questioned whether it was reasonable to order $6,000 worth of testing to evaluate the patient rather than performing more standard testing such as measuring the sedimentation rate or urinalysis. Dr. Lanson explained that when he initially saw the patient he thought she had chronic sinusitis and allergic reactions. The cost of the testing was related to testing for environmental triggers for her sinusitis and bronchitis. Dr. Connell questioned whether the membrane diffusion capacity testing (pulmonary plethysmography) Dr. Lanson performed was within the standard of care for an allopathic physician. Dr. Lanson stated that the testing he performed was done according to allopathic medicine standards and was not homeopathy. Dr. Lanson referred to several references to European literature that he provided during the investigation that supported the use of pulmonary plethysmography as a modality to treat vasculitis. Dr. Connell asked if Dr. Lanson could provide non-environmental medicine literature used by allopathic physicians that supported his treatment. Dr. Lanson stated that while there is evidence published in environmental medicine literature, he was not aware of common medical journals that published articles to this effect.

Dr. Lanson stated that patients are given total informed consent for the type of practice he has and about the modes of evaluation he employs. He described the principles of evaluation in environmental medicine and told the Board that these principles are described to patients up front so that they understand how his practice is different from other allopathic physicians. Dr. Connell clarified with Dr.

Lanson that the Mayo Clinic is an authoritative and recognized allopathic diagnostic and treatment center. Dr. Connell asked Dr. Lanson if he understood that after seeing him the patient went to Mayo Clinic and was not diagnosed as having vasculitis, but rather, fibromyalgia. Dr. Lanson stated that he did not disagree with the diagnosis of fibromyalgia. However, it was his intent to find the cause of the patient's complaint and she did have signs and symptoms of vasculitis.

Ronnie R. Cox, Ph.D. asked Dr. Lanson if he explained the dimensions of environmental medicine to the patient during his two visits with her and if he explained the costs of his service to her. Dr. Lanson stated that his office manager meets with patients after he sees them to review costs and the costs for which the patient would be held responsible. In this case, the patient provided misinformation about her insurance coverage, which resulted in her being held liable for some of the costs that normally would have been covered by insurance.

Lorraine Mackstaller, M.D. asked whether the charges for the patient would have been the same regardless of whether she had insurance. Dr. Lanson explained that if the patient had Medicare as a primary insurer his office writes off some of the costs. Dr. Mackstaller then questioned the laboratory data that showed a CRP test within normal limits and if Dr. Lanson would have expected it to be elevated in a patient with vasculitis. Dr. Lanson replied that the sedimentation rate would be elevated in a person with immune vasculitis, but this patient had a history of chemical exposure so inflammatory markers might not be present. He also explained that the patient was covered with cherry angiomas, which are signs of chemical exposure. Dr. Mackstaller asked if Dr. Lanson ever considered sinusitis instead of vasculitis. Dr. Lanson agreed that the patient had sinusitis.

Robert P. Goldfarb, M.D. asked Dr. Lanson about his patient load of how many cases of vasculitis he typically encounters. Dr. Lanson stated that he sees about one case of vasculitis about every two months. Dr. Goldfarb also questioned Dr. Lanson's billing for a level 5 new patient examination, including a pollen series for $864, a mold series for $552 and pulmonary testing for between $2,000 and $2,500. Dr. Goldfarb asked if Dr. Lanson did these tests on every patient who comes to the office. Dr. Lanson stated that he ordered these tests on this patient because of her pulmonary history, but he does not perform full testing like that on every patient. Dr. Goldfarb noted that these tests and others that were ordered came out to a total of $6,032.60 and the workup was exhaustive for a patient who was only seen twice. Dr. Lanson stated that his office never billed the patient once they found out that she was not a primary Medicare beneficiary. Instead, they discussed the ramifications of the bill with her. Dr. Goldfarb asked why Dr. Lanson did not start with less expensive preliminary testing. Dr. Lanson replied that when he ordered the tests his office assumed she was a Medicare patient. He added that he does what is right for the patient. In retrospect, Dr. Lanson stated that he would have still ordered the allergy testing, but he probably would have ordered less pulmonary testing.

Ram R. Krishna, M.D. continued the line of questioning regarding Dr. Lanson's billing practices and how long it would have taken his staff to perform the tests. Specifically, Dr. Krishna questioned how Dr. Lanson could do everything that a particular code required him to do within the time period Dr. Lanson stated that a particular procedure took. Dr. Lanson stated that while some procedures were billed as though they were completed in one day, they could have been performed in two settings. Dr. Krishna noted that the billing records indicate that the testing was completed in one day.

Douglas D. Lee, M.D. questioned whether the billing was unbundled and asked Dr. Lanson if there were billing codes he could have used to combine multiple tests under one code. Dr. Lanson replied that he was unaware of alternative codes.

Dr. Connell clarified that the pulmonary testing is conducted in the office and the results are derived from a computer. He questioned how Dr. Lanson could diagnose the patient with abnormal diffusion capacity when the computer results show pulmonary diffusion within the normal range. Dr. Lanson replied that although the computer reading was normal, there is formula to determine the membrane diffusion capacity and that the patient's membrane diffusion capacity measured as being abnormal. Dr. Connell then questioned the billing records. Specifically, the records state that there were ten dates of service, although Dr. Lanson admitted to only seeing the patient twice. Dr. Lanson stated that the patient could have come in for allergy testing on days when he did not see her. Dr. Connell also questioned antigen drops that Dr. Lanson prescribed and charged the patient for, but that she never picked up from his office. Dr. Lanson explained that his office made the drops for her and she approved of the charges before they were made. Dr. Connell asked if this form of treatment was widely accepted in allopathic medicine. Dr. Lanson responded that it was an accepted form of treatment, but that articles written about the subject are not commonly published in traditional allopathic medicine journals.

Mr. Giancola made some closing remarks to the Board. In regard to the billing, he conceded that there was a lot of discussion, but assured the Board that Medicare accepts the procedures and testing for which Dr. Lanson billed. Dr. Lanson has received no indication from Medicare that he has billed inappropriately. Additionally, Dr. Lanson's office staff goes over the charges with the patient and for what charges the patient will be billed. Secondly, another physician who prescribed her vitamin shots and a rheumatologist previously saw this patient. Each had their different opinions regarding the patient's medical problems. Mr. Giancola stated that this was a patient with multiple medical problems and all of the physicians who saw her, including the physician at the Mayo Clinic, had a different conclusion. Lastly, Mr. Giancola explained that environmental medicine is part of allopathic medicine and that Dr. Lanson provided references from a professor at a well-respected medical school who stated that Dr. Lanson met the standard of care. By diagnosing the patient as having vasculitis instead of fibromyalgia Dr. Lanson was assessing the cause of her condition. Mr. Giancola reiterated that Dr. Lanson is practicing within the standard of care and is practicing within the standards for his specialty.

Dr. Connell concluded his comments by stating that based on the preponderance of the evidence and on the extensive material that he has read that Dr. Lanson is not practicing in a conventional allopathic fashion. Additionally, the misdiagnosis of vasculitis was based on unconventional testing, and as a result, Dr. Lanson recommended unconventional treatment.

MOTION: Patrick N. Connell, M.D. moved for a finding of unprofessional conduct under A.R.S. §32-1401(27)(q) – Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.

Dr. Connell stated that the preponderance of evidence did not support a finding of unprofessional conduct under A.R.S. §32-1401(27)(w).

SECONDED: Ronnie R. Cox, Ph.D.

Dr. Connell stated that the standard of care in diagnosing vasculitis would be to use a standard approach and standard accepted testing to establish the diagnosis before embarking on a course of very expensive and unconventional treatments that are not generally recognized by allopathic practitioners. Vasculitis is potentially life threatening and if not treated appropriately the patient could have significant pulmonary, renal or other consequences. There is the potential harm to the patient for undergoing unnecessary treatment.

Dr. Goldfarb stated that while the billing for bundled or unbundled services is illogical at times, the Board does not have a specialist to look at those charges. At this time, the Board should concentrate on the care provided to the patient. Dr. Lee agreed that there was an appearance of inappropriate billing, but there was no formal accusation. Dr. Cox agreed and noted that there was clear communication between the physician and the patient and the patient bore some responsibility.

VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED

MOTION: Patrick N. Connell, M.D. moved to draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for misdiagnosis of vasculitis in part on unconventional therapy.
SECONDED: Douglas D. Lee, M.D.
ROLL CALL VOTE was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Lorraine L. Mackstaller, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, Ph.D., R.N.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED

3.	MD-04-0484A MD-04-1010A	M.R. M.B.	HOWARD L MITCHELL, M.D.	30004	Draft finding of facts and conclusions of law for a letter of reprimand for excessive prescribing of narcotics and for the failure to maintain adequate records. The physician will be placed on probation for one year, during which time he must complete board approved CME in pain management, and board approved CME or a PACE record-keeping course, at the physician's expense. The continuing of education is in addition to the requirements by the bi-annual license renewal.

Dr. Mitchell appeared without legal counsel.

Roderic Huber, M.D., inside Medical Consultant, made a presentation. Merick S. Kirshner, M.D, outside Medical Consultant, reviewed the case. Howard L. Mitchell, M.D. is a psychiatrist. The Board received three separate complaints for over prescribing narcotics. The standard of care would be to carefully prescribe indicated pain medication according to Arizona Medical Board (AMB) and the Drug Enforcement Agency (DEA) guidelines. Dr. Kirshner felt Dr. Mitchell's records were difficult to read and interpret. It was almost impossible to correlate office notes with prescriptions and refills. Based on pharmacy printouts, Dr. Kirshner was convinced that Dr. Mitchell was excessively prescribing pain medication. He also felt during the investigative interview that Dr. Mitchell was evasive and poorly focused on the problem.

During Dr. Mitchell's opening statement he indicated that he believed it was not the patients who made the accusations. He felt the complaint came from the husband of one patient and the parent of the other two patients. He stated that the investigative interview focused on interpretations of his handwriting and not on over prescribing. Dr. Mitchell agreed that his handwriting was small and there was a lot of information in his notes. His private practice is in general psychology. He has many challenging patients. Two-thirds of Dr. Mitchell's patients are referred to him from neurologists, pain clinics, and OB Gynecologists. He stated that the referring physicians send the patients to him after they have gone as far as they can with managing pain.

Dr. Mitchell stated that he does pain medication management, but does not handle pain procedures. He is a member of the American Academy of Pain Management and the American Headache Society and regularly obtains continuing medical education. He performed his residency under Dr. Michael Less of the Maricopa Medical Center. Dr. Mitchell feels that psychiatric patients get short changed in treatment of their medical pain problems because the patients often talk about feelings rather than facts. He spends a lot of time working with these patients. He does not have a large cliental. One of the situations he runs into with his psychiatric patients is that they are not compliant with their medication and treatment regimens. Dr. Mitchell feels if these patients have other medical problems in addition to the pain he does not expect them to be as compliant as other patients. In psychiatry he faces problems with being unable to abandon a patient or fire a patient as in other areas of medicine. He cannot hold patients to a contract the way a pain clinic can. This is usually why pain clinics refer patients to him. Dr. Mitchell explained that dealing with F.B. and A.R. (sisters) was a delicate situation because of the family history with suicide. He does not feel he could abandon them.

William R. Martin III, M.D., led the questioning and stated that he would deal with both cases combined. He commented that he had much difficulty reading Dr. Mitchell's handwriting. Dr. Martin indicated he would focus his questioning around the records and standard of care. Dr. Martin referred to Dr. Mitchell's response letter to the board dated May 19, 2004 and to his opening comments regarding

being held to a higher level and not having the ability to fire a patient. Dr. Mitchell indicated this was not an issue with all cases. He emphasized that even when he has to ask a patient to find another physician that he is almost forced to continue to treat them until they find another doctor. If they do not find a doctor then sometimes he must continue to treat them as best as he can.

Dr. Martin asked Dr. Mitchell to describe some of the symptoms he deals with for psychiatric conditions. Dr. Mitchell listed depression, anxiety, and obsessive-compulsive disorder. He explained that when dealing with obsessive-compulsive disorder if the patient-physician relationship became unpleasant he could fire them but there would still be follow-up such as letters to write, referrals, and recommendations. If the patient became suicidal after abandoning them, it would place the responsibility on the physician. Dr. Martin agreed that it would be unethical and inappropriate to abandon a suicidal patient, but felt it would not be an issue to abandon a non-depressive patient. Dr. Mitchell agreed that there are different levels of endangerment to the patient; some are easier than others to move on. Dr. Mitchell feels his role is to help people from moving into the public sector where the worst of the worst are seen.

Dr. Martin asked if Dr. Mitchell felt he had practiced within the standard of care for these three patients. Dr. Mitchell felt he had. He commented that he is anxious to see DEA complete their online prescribing system. This system enables doctors to prescribe through a centralized computer system where a physician can instantly see all prescriptions. He feels this system will help to avoid many situations such as his. Dr. Martin referred to the May 19th letter that alleged the husband of one of Dr. Mitchell's patients, "possibly stole and used or sold her medications." Dr. Mitchell confirmed that he made the statement. The allegation was originally made by one of the two sisters and the other sister supported it. Dr. Mitchell commented that the husband of the patient A.R. has been to his office and apologized for submitting the complaint to the Board. A.R. had confessed to Dr. Mitchell that her husband made the complaint as a way of getting back at her because of marital difficulties.

Dr. Martin asked Dr. Mitchell if he had any suspicions that A.R. was not using the prescriptions being prescribed to her. Dr. Mitchell confirmed the suspicion and stated that he was told they had been stolen. He believed that to be the case. Dr. Mitchell said he continued to prescribe the narcotics to the patient and recommended she obtain a lock box to keep her and her sister's medicine in. The patient showed Dr. Mitchell the lockbox so he was able to confirm that she did follow his directions. Dr. Martin referred back to the where it indicated the husband was able to get beyond the lockbox. Dr. Mitchell confirmed this was true and that he instructed the patient to get a combination lock instead. Dr. Martin asked Dr. Mitchell why he continued to prescribe narcotics to the patient. He responded that he could not abandon the patient. She had a family history of suicide, she was type two bipolar, had anxiety and panic problems, fibromyalgia, and had been diagnosed with regional pain syndrome related to a previous rib injury.

Dr. Martin referred to the patient records for F.B. under medical illnesses that described the underlying medical condition that required narcotics. Dr. Mitchell reviewed the information and stated the patient had a previous suicide attempt by jumping, and had a history of low back pain and radiculopathy. Dr. Mitchell read from the records that she had LBP for low back pain since the suicide attempt in 2000. Dr. Mitchell did not make the diagnosis; the patient came in with it. Dr. Mitchell stated that he did not receive medical records from a physician or surgeon regarding the low back pain. Dr. Mitchell did receive a note from Dr. Killian, F.B.'s neurologist, permitting him to prescribe certain medications. Dr. Mitchell did not have a consult for this case.

Dr. Martin referred to the medical records for patient A.R. and asked what medical condition required excessive amounts of prescribing. Dr. Mitchell described that A.R. had been in a motor vehicle accident in 1995, had endometriosis, had chronic chest wall pain from R.S.D., and had fibromyalgia. She was on the medication for endometriosis when she came to him as a patient. Dr. Martin asked how he diagnosed R.S.D. Dr. Mitchell replied that she came in with the diagnosis and he referred her to a neurologists for evaluation of her pain and other neurological deficits. Dr. Martin questioned why Dr. Mitchell was prescribing narcotics for the patient. Dr. Martin stated that other physicians do not want to treat patients who are suicidal. These patients had a history of pain, both patients had dealt with suicide in their families, and had a long history of suicide ideation, and pain would have tipped them over the edge as it did with their aunts. Dr. Martin asked if Dr. Mitchell had submitted all the charts for these patients and he confirmed he did. Dr. Martin asked to see the consultation from the neurologist that requested large amounts of narcotics needed to be prescribed. Dr. Mitchell stated he had not got them back from the neurologist yet, but he still needed to treat the patient. Dr. Mitchell made several attempts to get the patient off of the narcotics. He stated that A.R. was off for a significant period of time, but she was unable to function. Dr. Mitchell confirmed that he assumed responsibility for treating the patients and prescribing narcotics without a record of proof of their diagnosis that he was treating them for.

Dr. Martin asked what the standard of care was. Dr. Mitchell replied that if at all possible to get a firm diagnosis with various conditions and he noted that with psychiatric patients it is not always possible to get help. In retrospect he would have done things differently. He still would have ended up with the responsibility of treating these patients and could not have abandoned them. Dr. Mitchell confirmed the standard of care is to prescribe medication for a specific condition. Dr. Martin referred to patient M.W. and reviewed the initial evaluation with Dr. Mitchell. Dr. Mitchell listed her conditions of pain and for seasonal headaches in the fall and winter. Her history showed a past treatment of illegal substance abuse. Dr. Mitchell did not feel comfortable prescribing medication for headaches in the summer and spring when her symptoms were fall and winter related. She had a long-term treatment of epilepsy. Dr. Mitchell explained her multiple problems with opioids and how she was nonfunctional without them. The patient had other problems with pain in her upper extremities, and a history of cervical osteoarthritis. There were no x-rays for the cervical osteoarthritis because the patient did not have insurance to get neurological testing. Dr. Mitchell did not feel that he could abandon her.

Dr. Martin recapped that all three patients received large numbers of narcotics, and in all three patients there was no evidence to support the need for long-term narcotics in terms of additional testing or consultation. Dr. Mitchell agreed with the recap and stated in retrospect he should have never accepted the patients into his care. Dr. Martin asked if the standard of care was met. Dr. Mitchell stated in retrospect that this was not something he would normally do. He continued that standard of care has to be modified somewhat when patients are suicidal, but that there are other ways to handle it. He stated the standard of care was partially met.

Dr. Martin questioned the percentages of time spent on the practice of pain management and Dr. Mitchell's educational background. Dr. Mitchell said he spent about 8 to 10% of his time on pain management. He took his residency at Maricopa Medical Center and studied under Dr. Michael Less who specializes in pain management. Dr. Mitchell stated that it is not common for a psychiatrist to include pain management with their normal practice, but that there is an emerging subspecialty in psychiatry in that regard. Pain management was included with Dr. Mitchell's psychiatry residency. He took 12 ½ hours of training in February psychopharmacology education and pain management in San Diego. Dr. Mitchell has also taken training through the Headache Society and the Academy of Pain Management. Dr. Mitchell does not consider himself an expert on headache management, but does treatment of difficult headache cases when the patients are psychiatric patients. Dr. Martin questioned the Dr. Mitchell's knowledge of cluster headaches. Dr. Mitchell stated that it is not part of his specialty and that he refers those patients to neurologists. He commented that cluster headaches should not be treated with opioids at first. If a resistance builds up to certain medications, not just with cluster headaches, there is no maximum dose of opioids. It varies between patients. Dr. Martin referred to patient M.W. who had cluster headaches. Dr. Mitchell stated that he felt it was reasonable that M.W. would take more than 12 Percocet per day, but felt that it was not good with regard to acetaminophen.

Dr. Martin asked Dr. Mitchell if he was aware that he prescribed 12 to 18 Percocet per day to some of these patients. Dr. Mitchell replied that he would not have prescribed that if he had known she was taking that much. He also stated that the patients had been conning him into rewriting prescriptions with various excuses. Dr. Mitchell realizes this was a bad situation and has taken measures to see that it does not happen again. Dr. Martin could not understand how Dr. Mitchell could be conned into writing prescriptions if his records were maintained properly with a chart in the front or back of the records that summarize what medications the patient is taking. Dr. Mitchell confirmed he did not use summary lists at that time, but is changing his practice to do so now.

Robert P. Goldfarb, M.D. noticed during the interview that Dr. Mitchell was having difficulty reading his records. Dr. Mitchell said he could read them fine, but was having a difficult time locating them on the computer. Dr. Goldfarb asked Dr. Mitchell if he had to take a six month sabbatical how would a replacement physician know what has occurred with these patients and what medications they were on. Dr. Mitchell stated he would not go on a sabbatical. Dr. Goldfarb suggested that it would be reasonable to take time off, but if the records cannot be read, how would a replacement physician know how many refills were given to a patient for multiple prescriptions. Dr. Mitchell explained that this was not the situation any longer that he has tightened things up. He is instituting a specific list of everything being prescribed. He does not dictate and continues to write long hand however. Dr. Goldfarb suggested to Dr. Mitchell that it is possible that a replacement physician would need to come in at some point and that it is something for Dr. Mitchell to think about as far as record keeping goes. Dr. Goldfarb added that the first thing one learns in pain management is ways to monitor patients. Patients who are seeking drugs will come to the practice and will give the physician a lot of difficult problems. Pain management teaches the physician how to avoid being scammed. Dr. Goldfarb suggested not allowing refills, or looking for a pattern when patients call for medications, or not to give the patient six months to twelve month refills at a time. He stated that it is not unusual for pain-seeking patients to try all sorts of scams. Dr. Mitchell replied that he does not give out refills beyond certain amounts of time and stated that these three situations were unusual because they were sort of supporting one another in a scam situation. Dr. Goldfarb told Dr. Mitchell that he has had good training, but he is not practicing what he learned.

Lorraine L. Mackstaller, M.D. inquired about the initial complaints and asked if a drug-seeking patient would complain against the doctor providing them the drugs. Dr. Mitchell stated it happens a lot when a physician abandons a patient, but it is not common. Dr. Mackstaller asked if there was a higher suicide risk in people that are drug-seeking such as the patient who had two suicides in her family. Dr. Mitchell stated that he now tries to eliminate those types of people from his practice. Dr. Mackstaller noted that she also had a difficult time reading the records, but was able to read a comment on August 4th about F.B. who was so tired she dropped her two-month-old son. Dr. Mitchell commented that sometimes when patients need opioids for pain there is too much sedation involved so stimulants are added. It is something Dr. Mitchell tries to avoid but it is necessary in some instances.

Dr. Martin referred back to patient F.B. and asked if she had been hospitalized for drug overdose. Dr. Mitchell explained that she had been taken to an emergency room. The parents thought it was an overdose. The father had called to let Dr. Mitchell know. Dr. Mitchell had tried to get the family to come in after the emergency room incident. The patient had verbally asked Dr. Mitchell not to pass on the information to her husband or family and he was trying to remain confidential. The father misunderstood Dr. Mitchell's intentions because he could not say too much. Dr. Mitchell wanted to wait until the family was together in the office to say things. Dr. Mitchell did not know the nature of the admission into the hospital, but did not feel it was for Tylenol toxicity. Dr. Martin pointed out that the medical records indicated F.B. was admitted to Banner Desert Medical Center for acetaminophen overdose. Dr. Mitchell stated that he if the records were not sent to him he would have no way of knowing. Dr. Martin said the second complaint was submitted because Percocet (another form of acetaminophen) was prescribed after that overdose. Dr. Martin read the complaint to the Board. "Dr. Mitchell continued to give my daughter large prescriptions of pain medication after he was told that she was addicted to them and was undergoing detoxification at Desert Samaritan Behavioral Health for the addictions. He agreed to stop at the time, but has since continued to give her large amounts, 240 pills of Oxicodone at a time. He was confronted by the family and refused to accept responsibility for this and tried to put the blame on us." Dr. Mitchell stated again this was the first time he had heard about this and if the patient does not give a signature for the records he cannot obtain them.

Dr. Mitchell gave a final statement. He felt it was interesting to see the emergency room records. Dr. Mitchell saw the patient right after she was discharged before they even went home. He did not have specific knowledge of what the doctors said. He stated that this patient went through her entire pregnancy hiding from him and her gynecologist that she was on medications. In retrospect he should never have accepted these patients and has tightened up all ways of doing things. Things should have been done differently and are now being done differently. He stated this was not the usual way he did things. Dr. Huber made a closing remark that in Dr. Kirshner's interview with Dr. Mitchell he stressed that Dr. Mitchell seemed unconcerned about medication side effects. Dr. Mitchell usually felt the primary care physician would monitor for that and that he would treat patients for general medical problems that would normally be treated in the primary care physician's care.

Dr. Martin summarized his findings as:

The first allegation of failing or refusing to maintain adequate records on a patient did happen. The standard of care was not met and therefore unprofessional conduct occurred A.R.S. 32-1401(27)(e). For the second allegation of prescribing, dispensing or managing controlled substance or prescription only drug for any other than accepted therapeutic purposes, Dr. Martin did not feel he had enough knowledge to comment on this in a definitive way. From the testimony he felt that cluster headaches should not be prescribed first line defense narcotics but there was not enough data to make a ruling on that. Dr. Martin bypassed on that allegation. The third allegation was A.R.S. 32-1401(27)(q), any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public. Dr. Martin stated based testimony today and on the hospital admission reports actual harm was done and the statute applies.

MOTION: William R. Martin III, M.D., moved to find the physician committed unprofessional conduct under statute A.R.S. 32-1401(27)(e)
SECOND: Ram R. Krishna, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED

The Staff Investigational Review Committee (SIRC) recommended that the physician receive a letter of reprimand for excessive prescribing of narcotics and has recommended CME and a PACE evaluation. Dr. Martin felt based on testimony, in terms of medical record keeping that there are issues and he recommended at the very least a CME for record-keeping be included as part of the discipline. Dr. Martin stated that most of the standards in terms of pain management have been violated in all three cases and feels the knowledge base in pain management had not been demonstrated in the interview. Dr. Martin recommended CME and PACE evaluation in those areas as well.

MOTION: William R. Martin III, M.D., moved to draft finding of facts and conclusions of law for a letter of reprimand for excessive prescribing of narcotics and for the failure to maintain adequate records. The physician will be placed on probation for one year, to completes board approved CME in pain management, and board approved CME or a PACE record-keeping course, at the physician's expense. The continuing of education is in addition to the requirements by the bi-annual license renewal.
SECOND: Lorraine L. Mackstaller, M.D.

Dr. Mitchell asked for clarification on how much CME is required in pain management and record keeping. Tim B. Hunter, M.D. said that Dr. Mitchell could contact staff to assist in finding a class. There is a standard class that can be taken. Ms. Christine Cassetta stated that the order would come back to the board for the final approval.

ROLL CALL VOTE was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Lorraine L. Mackstaller, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, Ph.D., R.N.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED

4.	MD-03-0437A	AMB	ANCA M. MARAS, M.D.	13103	Draft Findings of Facts, Conclusions of Law and Order for a Decree of Censure, for lack of medical judgment in administration of anesthesia and technical performance in several areas of a clinical practice, leading to potential and actual harm to the patient, and for repeated poor and/or inadequate documentation. In addition to the Decree of Censure a 5 year probation, which Dr. Maras may request to be removed after two years, to 1) work in some sort of group practice setting that will allow effective consultation when needed for patient safety issues, and 2) for periodic chart reviews with stipulations, to assure adequate documentation is performed.

Dr. Maras brought legal representation, Mr. Joseph Kendhammer.

William Wolf, M.D., Board Medical Consultant, gave a presentation to the Board. The case came to the attention of the Board on January 22nd, 2003 as a result of statutory reporting and the suspension of Dr. Anca Maras' hospital privileges by Desert Samaritan Medical Center. There were several allegations:

1) Dr. Maras' rate of epidural blood patch following labor epidurals and spiral anesthesia was above the national average and according to her peers. 2) Hospital privileges were suspended concerning issues of quality of care that include increased patient pain and suffering, extended hospital stays and readmissions with lower patient satisfaction. In that allegation peer review by the anesthesia committee additionally cited increased costs, impact on hospital census, staffing, increased liability exposure. 3) Dr. Maras failed to document her anesthesia care in a legible and understandable manner. 4) This is a separate issue, but related to allegation number 1. Dr. Maras negligently performed labor epidurals and spinal anesthesia requiring above average rate of epidural blood patch. 5) Dr. Maras failed to employ basic anesthesia monitoring such as use of a capnograph. 6) Dr. Maras failed to seek assistance in complicated cases. 7) Dr. Maras failed to use evasive monitoring modalities when indicated. 8) Dr. Maras improperly prescribed medications. 9) Dr. Maras failed to appropriately recognize and treat complications.

An outside Medical Consultant (OMC) analyzed the case. As a proposed standard of care, the OMC stated that there are many standards applicable to this review. He states that first are those of the American Society of Anesthesiologists. He states attention should be called to the guidelines for the ethical practice of anesthesiology including the AMA principles of medical ethics. The OMC stated that there were multiple deviations from the standard of care. The OMC stated findings in each of the above listed allegations. The OMC noted that Dr. Maras has a long history of problems for which she received letters of reprimand and she surrendered her license in New York and Florida subsequent to problems in Arizona. There has been loss of hospital privileges at two or more hospitals in Phoenix as well as a history of falsification of medical records on one or more occasion. Under aggravating factors the OMC states that Dr. Maras refuses to admit that she has any problems and fails to take responsibility for her actions, claiming that all of her care is proper and that this is only an attempt to discredit her. He states that she denies the necessity to take additional training and is resistant to outside independent observation of her anesthesia skills.

The Staff Investigational Review Committee (SIRC) noted that Dr. Maras attended a two-day PACE evaluation in September 2004. The report notes that PACE determined that Dr. Maras has a satisfactory knowledge base and can return to the practice of anesthesia. In examination of the PACE report of March 15, 2005 it was noted that Dr. Maras had accrued approximately 60.25 hours of CME during the three months prior to her phase 1 assessment. On the basis of the evaluation it was recommended that Dr. Maras return for the five-day clinical education program and the department of anesthesiology. Dr. Maras completed phase 2 of the pace program February 7, 2005 and PACE faculty determined that Dr. Maras has a satisfactory knowledge base and that she was likely prepared to practice anesthesia safely. It was noted that she took and passed a final examination at the end of the week. Faculty had agreed that she had made significant improvements in her knowledge base and approach to anesthetic management during her training. In addition to the 6,000 pages in the case file, the board received a supplemental packet dated August 5, 2005. The packet includes a 14-page letter from Dr. Maras' attorney, which is in part an indictment of the OMC's position as objective investigator, indicating that the OMC has instead become an advocate or prosecutor. The letter cites sections of the 6,000 pages to support the attorney's position. The supplemental information also includes 6 letters of support from physicians and colleagues of Dr. Maras most of whom are obstetrician/gynecologists.

Dr. Maras thanked the Board for giving her an opportunity to clarify a few issues that occurred during her practice. She stated the case was not accurately presented. Dr. Maras stated the way the case was presented that it showed her as a physician not approved by her education, her training, and her letters of references from her colleagues. Dr. Maras explained that she had a few issues with the Board that were clarified and she followed the recommendations. In 1984 Dr. Maras had a malpractice suit. The case finally went to trail in 1990. The parties involved, the obstetricians and Dr. Maras, won the case. During this time the Board issued a letter of reprimand for not recognizing a cardiovascular collapse. She disagreed with the finding and stated this was for a patient that had an amniotic fluid embolism. She saved the baby and the mother died. Dr. Clark of Utah proved the situation and what happened. Dr. Maras stated the Letter of Reprimand started to haunt her up until 1996. She applied for privileges at seven hospitals, between 1988 and 1989. One of the hospitals, Boswell, stated the application was falsified because of the questions initially were involving a lawsuit and she answered no according to her understanding of the question. Dr. Maras had given the explanation of the malpractice to the Arizona Medical Board and to other hospitals that accepted the answers and so Boswell let her reapply. Thunderbird, the hospital that issued this complaint to the Board, terminated Dr. Maras' employment. She did not reapply or fight the issue because she did not want to practice there anymore. Dr. Maras continued to practice at Desert Samaritan, Good Samaritan, Humana, Arizona Heart Institute, and St. Joseph's. All of these organizations accepted Dr. Maras' explanation and they changed the application after that issue. Dr. Maras does not consider herself a physician that falsifies applications. It has not happened since that incident. With the issue of patient care, Dr. Maras stated that when she touched a patient, that is when she began to care for the patient. Dr. Maras claimed to have never received any complaints of any wrongdoing as described by Mr. Wolf.

In 1989, a complaint from an anesthesiologist was issued that stated Dr. Maras falsified anesthesia records. Eventually that physician retracted the complaint and the board did not take any action. That physician apologized to Dr. Maras and the medical staff, and then called the Board and stated that he made a mistake and he retracted his complaint. Dr. Maras stated that the other cases in 2000 and 2001 regarding blood patches, not using a capnometer, and the DIC case were not reported the way they happened. Dr. Maras stated that she is a safe physician and is not a danger to her patients. The issue that started the complaint, that was proved by PACE, was presented on the same day that the other cases were presented because of an anti-competitive behavior at Desert Samaritan in the OB department. The setup of the OB department is unique. They have two or three anesthesiologists that are covered in the OB department, some of them are representatives of groups and some are independent like Dr. Maras. In 1999, a request for a proposal was circulating among the anesthesiologist. The proposal was not acceptable to Dr. Maras. She felt she should be on call only three days and the remaining days should be divided between the groups. Whenever Dr. Maras' office was contacted for anesthesia in the OB department, the other colleagues would pick up the cases and give their own opinion on those cases. None of the cases were picked up by the QA department instead they were picked up by the anesthesiologists on 24 hour call and reported to the medical staff. Dr. Maras felt that this was not fair.

Douglas D. Lee, M.D. led the questioning of the case and focused his questions on two basic issues: 1) documentation, and 2) the medical management of the patient judgment on technical issues. Dr. Lee asked about Dr. Mara's practice. Dr. Maras stated she practiced only at Desert Samaritan. She had privileges at other hospitals but did not exercise those privileges. Out of 800 to 1000 cases per year, about 60 to 70% were obstetrical related. The other 30% were Gynecology related. In the obstetrical anesthesia practice Dr. Maras felt she received more critical care cases than her colleagues because she use to cover for both groups in O.B. If help was needed to push a patient, or a patient was ready to deliver, the other anesthesiologist would often refuse to help. Dr. Maras would help if they needed it.

Dr. Lee questioned the documentation issues and referred to the first physician record dated January 8, 2001 for patient K.T. Dr. Lee asked Dr. Maras to run through the continuing epidural procedure. Dr. Lee asked questions relating to the written notes in the file for Lidocaine and Bupivacaine and asked Dr. Maras to interpret the dosage amounts, which she did. Dr. Maras stated that she did not write

down the dosage for the quarter percent of Bupivacaine because she did not use it in the epidural. Dr. Maras went farther with the Lidocaine and 5 cc's of Fentanyl and did not use local anesthetics. Dr. Lee asked Dr. Maras, as a certified anesthesiologist, if she felt it was adequate to use 3 cc's or 45 milligrams of Lidocaine as a test dose and 50 micrograms of Fentanyl in an obese patient for labor. Dr. Maras felt that it was adequate. She clarified that if the patient was two centimeters you do not need more. Some patients need more but as a start, in order not to produce too much motor blockage or to actually affect the labor, you use as little as possible. Dr. Lee accepted her opinion but did not feel it was typical.

Dr. Lee referred to the Aseptic conditions on the lower part of the chart that discussed the different lumbar placements for the epidural catheter. Dr. Maras explained her notes in the chart and translated them to mean that she was not successful at the L2 or L3 lumbar so she went to the L1 and L2 lumbar. Dr. Lee noted that it was difficult for him and the outside Medical Consultant to interpret and read the chart the way it was written. Dr. Maras stated the patient ended up having a spinal headache. Dr. Lee stated there was some confusion surrounding the headache in the postoperative phase. People did not know if it was a due to a previous headache or what. Dr. Lee reviewed the chart and could not find where it noted complications. Dr. Maras explained that the charts are complicated to read but her experts do not have a problem reading them. The labor and delivery charts were created for labor specifically and not for anesthesia. Dr. Lee referred to the same chart and to a chart that was filled out by another anesthesiologist in 1996. He stated that in comparison, the other chart was more concise and still there was not a lot of area for commentary. The physician marked in his other area of notation that the procedure itself would be under additional notes. Dr. Lee indicated that the physician wrote in a very typical fashion. Dr. Lee noted that Dr. Maras trained in New York and he believed the training to be similar to most places that describe the overall positioning of the patient, needle size, and most importantly, whether there was any notice of any complications. Dr. Lee proposed that there areas available for charting of procedure and potential adverse effects. Dr. Maras replied that her patient's position was recorded on the previous page under vital signs. She stated there is a different way of expressing what took place but she did record the information.

Dr. Lee stated the confusion in the cases was from the documentation. There were a number of days, while working up a headache for the patient, that several tests were performed to determine the cause of the headache. Dr. Lee suggested the physicians could have treated part of the headache had the issues of difficulty been mentioned on the chart. Dr. Maras explained how the difficulty with the procedure was documented when she listed the times the epidural started and when she gave the first test dose. She explained it should take five minutes, but her chart showed it took 20 minutes. Dr. Lee indicated that not everyone would know how long it takes to place an epidural in the spine. Dr. Maras replied that the progress notes discussed the difficulty with the epidural as well.

Dr. Lee reviewed patient L.S.'s records, which were another documentation situation. Dr. Lee reviewed the chart with Dr. Maras and clarified certain acronyms and abbreviations she used to describe dosages, medications, needle sizes, and procedures. Dr. Lee clarified the written notes regarding the patient's comments, conditions, and complications. Dr. Lee discussed in the procedure used in the combined spinal epidural in the placement of the Tuohy needle. Dr. Maras explained the needle is used to identify the spinal compartment or subarachnoid space. Once that has been identified then the needle is removed and the medication is administered through a spinal needle. The spinal needle is then removed and the epidural catheter is placed. In this particular case the procedure was not a combined spinal epidural (CSE). Dr. Maras stated this was a difficult case and she used the spinal to identify where to place the epidural catheter for the C-section. Dr. Lee stated it did not seem reasonable to place an L1-2 for a CSE, he felt it was very high, purposefully, and noted the cord ends up there and he would not advise doing a spinal at that point. Dr. Maras defended her actions based on the size of the patient, the scoliosis, and the concern she had regarding a previous anesthesia procedure that was unpleasant for the patient. Dr. Lee explained the reason he discussed the record was to go through the sequence of events to know what anesthetics were done. The patient ended up with a headache afterwards and the procedure to treat the headache would have been different depending on the size of the spinal puncture. Except for the difficulty that was noted, there was no mention positively or negatively of CFS. Dr. Lee asked if an epidural blood patch was done on the patient and Dr. Maras answered that it had been done.

The last patient record Dr. Lee reviewed in regards to documentation was L.M. He mentioned again that it was difficult to decipher the chart. Dr. Lee was able to determine the medications used, but was unable to determine if it was a spinal or an epidural. Dr. Maras explained that it was a spinal based on the .75 and the medication used. Dr. Lee stated for the record that the outside medical consultant criticized the use of three quarters percent margin. He stated it was not recommended for epidural use, but would be standard and appropriate for a spinal anesthetic. Dr. Lee reviewed with Dr. Maras the dosages and the method in which they were written. Dr. Lee felt the way the medication doses were written were unusual because most people would write what the concentration was and the total milligrams instead of allowing someone to calculate it.

Dr. Lee discussed the percentages of Lidocaine that was used. Dr. Maras stated they were low because she used the Lidocaine as a local anesthesia. Dr. Lee again suggested that people would typically write in the procedure that they used local anesthetic versus what is in the subarachnoid space. He found the charting to be confusing. Dr. Lee stated the outside medical consultant and he both had questions regarding the airway comments. Dr. Maras explained the patient came in on an emergency basis for C-section and complained of shortness of breath. Dr. Lee asked what the check mark next to "check of the trachea" meant. Dr. Maras stated that the patient had a mask of oxygen on and the check mark meant she had checked the patient's chest, equal breath sounds, and equal chest expansion.

Dr. Lee switched the questioning to the medical management side and referred to the anesthesia record for patient K.C. This patient had a delivery with postpartum hemorrhaging and went to a hysterectomy post delivery. Dr. Lee led discussions around the anesthetic chart that related to the postpartum hemorrhaging. Dr. Lee asked if 5 milligrams of Pentothal was appropriate on a 175-pound patient who was hemorrhaging. Dr. Maras stated under certain limits it would be okay. Dr. Maras explained the conditions of the situation as: The patient was in labor and had an epidural level, it occurred 2 hours after she was in the recovery room, she was already fully dilated and replaced, she was bleeding, and she had stable vital signs. Dr. Maras added that fluids were given to the patient and the 5 milligrams were not shoved into the patient at one time. The patient was given half the syringe and was still awake and fully aware of

her surroundings. Dr. Maras did not feel she had any other option then to administer the other half of the syringe. It was not a fatal dose.

Dr. Lee asked if Dr. Maras agreed that the normal dose in a non-hemorrhaging OB patient would be around 4 milligrams per kilogram. Dr. Maras did not believe that it should be fixed. She felt it should be according to the circumstance and should range between 2 and 4. She noted that some textbooks indicate a range up to 8. Dr. Lee asked where it indicated the incremental doses in the charts. Dr. Maras said it was based on the vital signs. If a bolus dose had been given the blood pressure would have dropped and it did not.

Dr. Lee explained his understanding of the transfusion procedure: The patient lost 1200 ccs of blood, which prompted the surgeon to go back for surgery. As stated by Dr. Maras the patient was euvolemic and the Pentothal dose did not drop the patient's blood pressure. During the second operation, according to the surgeon, the patient lost 600 or more ccs of blood in PACU. Then possibly another 2,000 ccs of blood were lost in the recovery room for a combined total of approximately 4,000 ccs. Dr. Maras gave 20 units of packed cells to the patient. This is for an 80-kilo patient with a total blood volume of about 6 liters. Dr. Lee reviewed the patient's hemoglobin stats: preoperatively the hemoglobin was at 12, just prior to the second surgery the hemoglobin was at 8, and postoperatively the hemoglobin was at 20. After the review of the situation Dr. Lee asked Dr. Maras to calculate how she determines how many packed cells to give to a patient with x-amount of blood loss. Dr. Maras stated that she would calculate the hematocrit and the blood volume and would use 30% hematocrit and 30% of the amount she wants to reach before transfusing to create a trigger transfusion point. Dr. Maras stated that this patient was bleeding and not coagulating. The only thing she could do was maintain the oxygen and carrying capacity, and to maintain her platelets and the whole coagulants. Dr. Maras had to weigh an over-transfusion versus having a dead patient on the table.

Dr. Lee questioned Dr. Maras' knowledge of the number of packed cells to use for patients in a normal situation who had lost 500 or 1000 ccs. Dr. Maras replied that she could not answer the question without having the HNH and lab results. She stated that this was an impossible situation to deal with. She had tried everything she could to help the situation and nothing worked. She contacted Dr. Suleiman for help. Dr. Maras explained the situation to him and he recommended she do a couple of things and that she just infuse and he would come in. When Dr. Suleiman arrived he could not do anything more than she had already done. Dr. Lee reviewed the situation and determined the amount of blood lost was about eight units and at the most 10 units of packed cells should have been transfused, 20 units were given. Dr. Lee asked Dr. Maras if she calculated one unit of packed cells to one gram of hemoglobin. Dr. Maras stated that she did. Dr. Lee replied that the patient did well from a surgical standpoint, but was in the intensive care unit for a while intubated with pulmonary edema and fluid overload. Dr. Lee reviewed the findings in the chart that showed the patient was stable yet at the same time blood was being poured into her. He did not agree with these findings. Dr. Maras explained again the situation and that she had to choose between over transfusing with 5 days in intensive care unit versus a dead patient. It was an easy decision for her to make.

Dr. Lee referred to the hospital records for a non-emergency patient L.O. and stated the general focus was on the discussion on the End Tidal C02 monitor. In response to Dr. Lee, Dr. Maras explained that the general anesthesiologist was selected because of the difficult shunt and the indication from the neurologists not to patch her back. Dr. Lee asked Dr. Maras to describe her typical machine check. Dr. Maras listed the check as follows: The equipment is placed in the operating room in the labor C-section room to start in the event of an emergency. The oxygen is checked for high and low. The heart monitor is put on position. The blood pressure is put on the arm board. The EKG is ready to go. The medication being used in surgery is ready to go.

Dr. Lee focused questions on the CO2 monitor and asked if it was placed on sleep prior to the surgery. Dr. Maras confirmed it was on. Dr. Lee asked when the patient was intubated was Dr. Maras able to see the End Tidal C02. Dr. Maras replied that she could not see anything, it was on, but it was zero. The green light was down towards the bottom. Dr. Maras explained the sequence of events that occurred. When she attempted to insert the tube the first time it was difficult to do and because she was unable to get assistance she removed the tube and attempted to ventilate by mask. When Dr. Maras tried to compare the C02 ventilation waves she mistakenly put the CO2 monitor on sleep mode. The second attempt to insert the tube, she used a needle and called for the code team from the emergency room. When Dr. Maras went to switch the machine from the sleeping position to the on position, the nurse from the labor and delivery room already had her hand on the button. Dr. Maras removed the tube again. Dr. Tucker came to assist and was also unable to insert the tube the first time. Dr. Maras explained to Dr. Tucker that the patient had a deviated larynx. The second time Dr. Tucker was able to insert the tube successfully. The saturation levels had gone down to 22 and that the patient remained intubated for two days. The patient was sedated, but was alert and aware. Dr. Maras explained that when Dr. Tucker came in to the room, he made the assumption that she had never recognized esophageal intubation. Someone had made an order that Dr. Maras was bagging the patient. Dr. Maras stated that the tube has to be bagged in order to make sure you know where you are. The nurse was checking on the check when Dr. Tucker came in.

Robert P. Goldfarb, M.D. stated the Board had made a number of allegations after reviewing all the complaints. Dr. Goldfarb asked Dr. Maras if she felt any of the allegations presented were true and if she had fallen below the standard of care in any of the 10 allegations. Dr. Maras stated she did not fall under the standard of care and that none of the allegations were substantiated. Dr. Goldfarb referred back to the patient with the lumbar puncture where Dr. Maras' attempted to do a L2-3 then after difficulty moved to L1-2 and asked Dr. Maras to explain why she started at L2-3. Dr. Maras explained that the patient was heavy and had scoliosis. She felt she could start at L2-3 was because it was the biggest epidural space and she could feel the bone better. Dr. Goldfarb asked where the spinal cord ended. Dr. Maras replied above L2-3. Dr. Goldfarb corrected her and stated it was normally L1-2.

Dr. Goldfarb asked Dr. Maras to describe the process of the Tuohy needle. Dr. Maras confirmed that the needle is a 17-gage and has a little bend to put the putting a catheter in. After the position is located the needle is rotated and the catheter is then inserted. Dr. Goldfarb asked if Dr. Maras inserted any other needle. Dr. Maras said that she did insert the spinal needle behind the tip. Dr. Goldfarb asked if at L12 the spinal cord was hit what would happen. Dr. Maras stated that the patient would let you know because it is very

painful. Dr. Goldfarb asked what complications could arise from hitting the spinal cord. Dr. Maras said if the patient is in pain then you take it out. Dr. Goldfarb stated that was not a good test to be doing, the object is not to hit the spinal cord and if you do there could be possible injury to the spinal cord. Dr. Maras did not agree. She stated that if a patient needs to have the pump or pain medication higher, then it must be done carefully. Dr. Goldfarb asked if it is dangerous to do an L1-2 puncture without C-arm fluoroscopy. Dr. Maras stated that everything she does is dangerous, even L4-5. She is trained and knows what to do to avoid the trap.

Mr. Kendhammer, legal counsel, gave a closing statement. He stated that he was amazed at the amount of documentation presented in this case. Mr. Kendhammer noted that the Board obviously must rely on a reviewer with this much documentation. When he went through the reviewer's report, and compared the allegations to the supporting documentation, he put together a supplemental report of things he felt were unusual and was obvious errors on behalf of the reviewer. It was not the intention of Mr. Kendhammer to indict Dr. Stein, the medical consultant. Mr. Kendhammer stated that Dr. Stein made factually incorrect and inconsistent statements. Mr. Kendhammer stated that the two expert physicians, retained by Dr. Maras, had received summaries and medical records, yet Dr. Stein stated they had not. One of the physicians stated he ignored the summaries and only looked at the medical records, and the other physician said she reviewed two summaries but relied on the medical records. Mr. Kendhammer felt the board needed to know what really happened in the cases in order to take action. He was happy that Dr. Lee took the time to look at the individual medical charts. Mr. Kendhammer noted that Dr. Lee pointed out the handwriting issues and that some people would have a difficult time deciphering the handwriting. Mr. Kendhammer stated that Dr. Lee acknowledged some of the later records were easier to follow, which is a medical charting issue. According to the outside medical consultant report, certain amounts of medication were inappropriate, but the supplemental information shows the medication was correct based on the situation. At the hearing, the Board determined Dr. Maras should submit to a PACE evaluation. Dr. Maras complied and it was unanimously agreed by faculty members that Dr. Maras has the medical competence to perform anesthesia and is not a danger to patients. Mr. Kendhammer questioned why the Board would send the doctor to PACE if it was not the Board's intention to follow the PACE recommendation. Mr. Kendhammer understands the concerns and does not feel disciplinary action is appropriate. Placing her on probation will make it almost impossible for her to obtain hospital privileges. If the Board finds that she is a danger to future patients, it will effectively end her career. Non-disciplinary action would be more appropriate. Mr. Kendhammer also offered to the Board that Dr. Maras would be willing to voluntarily submit to any number of chart reviews, for whatever frequency the Board would request.

Tim B. Hunter, M.D. stated that the case had been a long and difficult case for everyone. He noted that Dr. Lee dissected everything well for the Board.

MOTION: Douglas D. Lee, M.D. moved to issue a finding of unprofessional conduct for violating A.R.S. Statute 32-1401(26)(e) for failing to maintain adequate medical records, 32-1401(26)(q) for falling below the standard of care in multiple areas discussed including lack of use of standard monitoring, and A.R.S. Statute 32-1401(26)(11) for overuse of blood products that caused actual harm to the patient.
SECOND: Patrick N. Connell, M.D.
VOTE: 11yay, 0-nay, 0-abstain/recuse, 1-absent (Becky Jordan was absent)
MOTION PASSED.

Dr. Lee stated the initial SIRC report prior to PACE was suspension. The PACE evaluation showed that she did well in both phase 1 and 2 and should be considered as mitigating factors. After today's discussions and specifically Dr. Goldfarb's questioning, Dr. Lee still had concerns about the physician's judgment in terms of medical care. Dr. Lee felt Dr. Maras was somewhat cavalier as to not seeing any problems with her placing spinal needles in such high areas purposefully.

MOTION: Douglas D. Lee, M.D. recommended a Draft Findings of Facts, Conclusions of Law and Order for a Decree of Censure, for lack of medical judgment in administration of anesthesia and technical performance in several areas of a clinical practice, leading to potential and actual harm to the patient, and for repeated poor and/or inadequate documentation. In addition to the Decree of Censure a 5 year probation, which Dr. Maras may request to be removed after two years, to 1) work in some sort of group practice setting that will allow effective consultation when needed for patient safety issues, and 2) for periodic chart reviews with stipulations, to assure adequate documentation is performed.

Dr. Lee stated that he recommends the probationary period with chart review because he feels there is a short run between what Dr. Maras says after the PACE evaluation and what she may do in the future. Dr. Lee recommends the Decree of Censure because of her previous reprimand for issues similar to this. Dr. Maras had the same issues which appeared to have been corrected or at least were said to be corrected then the same things happened again.

SECOND: Patrick N. Connell, M.D.

William R. Martin, III, M.D. said it is rare to do a Decree of Censure versus a Letter of Reprimand. Dr. Martin asked if it is for the egregiousness of events or for the collective events from past actions. Dr. Lee stated it was for both because there were similar issues of monitoring in the previous reprimand. Dr. Lee also felt the doctor did not show any feelings that there were any problems on her part during Dr. Goldfarb's questioning. Dr. Lee agreed that a Decree of Censure is high, but he was considering suspension. She performed well in her PACE evaluation and Dr. Lee felt that indicated a Decree of Censure.

Dr. Martin asked if someone has a good evaluation from PACE and is deemed safe to practice, how can the Board say she has lack of judgment when an independent body says she has reasonable judgment. Ms. Cassetta clarified that the lack of judgment only referred to the patients Dr. Lee walked through and the instances that occurred with the patients. It does not apply to Dr. Mara's global skill as evaluated by PACE.

Dr. Lee's concurred with Dr. Martin that he had the same concerns because she did do well at PACE. Her previous records show that it looked like there were some corrections made after the supervisory issues were addressed and the Letter of Reprimand was given. It looked like things were going to go okay and then the exact same pattern happens again. It is the patterns that are disturbing, which is why Dr. Lee was recommended a Decree of Censure.

Dona Pardo, R.N., Ph.D. commented that there are instances where there is medical knowledge, but in transferring it over to the clinical area, the judgment is not there. Dr. Pardo suspected that was the issue here.

ROLL CALL VOTE was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Lorraine L. Mackstaller, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, Ph.D., R.N. The following board member was absent: Becky Jordan
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED

5.	MD-04-0902A	AMB	ERIC B. FARBER, M.D.	27406	Advisory Letter for a minor technical violation for A.R.S. 32-1401(26)(q) any conduct or practice that is or may be harmful.

Erick B. Farber was present with legal counsel, Fred Cummings.

Dr. Mark Nanney presented the case. This case was brought to the attention of the Board via a medical malpractice settlement. Patient J.N. was under the care of Dr. Farber for bilateral open angle glaucoma. J.N. developed a cataract in his left eye. He had surgery on May 8, 1997 and complications ensued. The patient's vision is permanently impaired as a result. The consultant concluded that Dr. Farber failed to perform an adequate vitreoretinal examination in the postoperative period of a complicated cataract extraction with rupture of the posterior lens capsule. Dr. Farber failed to discover the retained lens material. Dr. Farber responded and stated that the patient was stable in regards to the postoperative complications when he last saw him and he noted that retained lens material may be allowed to reabsorb. The medical consultant reviewed Dr. Farber's response and found it unpersuasive and recommends a letter of reprimand.

Dr. Farber did not give an opening statement.

Robert P. Goldfarb, M.D. focused questioning on the office records following surgery. Dr. Goldfarb asked Dr. Farber to read and explain to the Board each of the written notations in the record. May 8, 1997, day of the operation. Dr. Farber read 'phaco anterior vitrectomy ACIOL OS'. He explained that phaco is the abbreviation for phacoemulsification, which is the microscopic ultrasound technique of removing a cataract. He noted that anterior vitrectomy was performed because the posterior capsule broke during the course of removing the cataract. ACIOL was described as the type of intraocular lens that was put in the anterior chamber intraocular lens as opposed to posterior intraocular lens. OS is the left eye. May 9, 1997, postoperative in-office record. Dr. Farber read, 'pain very bad', which referred to the eye. 'T' indicated tension: intraocular pressure was 48, which Dr. Farber stated was very high and noted that between 10 and 20 is average. The pressure was reduced to 22 after an anterior chamber parasentesis released the eye fluid. '3+MCE' refers to micro cystic edema of the cornea; the cornea was edematous because of the pressure. 'Anterior chamber AC 2+ flare and cell' is an indication of inflammation. 'T ½ XE' refers to timilol time release. 'AM,AM' is a notation of both eyes. 'EP' stands for Econopred: a topical steroid. 'TOB' stands for topical Tobramycin: a topical antibiotic. The TOB is noted as 04, which is none in the right eye, four times a day in the left eye. 'NEP' stands for Neptazane, which is a systemic carbonic anhydrase inhibitor, used to decrease the intraocular pressure.

May 12, 1997, postoperative. Dr. Farber read and explained the notations. Dr. Farber read, 'the patients states it feels like a big lump in left eye'; which indicated there was a foreign body sensation. Pressure was 22. A slit-lamp examination was done and showed Striae Keratopathy, which is an indication that the intraocular pressure had decompressed. Dr. Farber explained that the cornea had folded, which is a combination of inflammation and decreased pressure. He stated there was continued inflammation in the anterior chamber. Dr. Goldfarb asked what the recommendation was. Dr. Farber recommended continuing the same treatment, which is indicated in the notations as 'P' for plan. May 19, 1997. Dr. Farber read, 'the patient stated there was no problem'. Dr. Goldfarb asked for clarification because the previous notation indicated a 'big lump'. Dr. Farber stated there was not a notation of vision in the record and explained that the patient was probably feeling better because of the topical steroid and the decreased intraocular pressure. The pressure was 23. Dr. Farber continued reading '2+ striae' meant the cornea folding had reduced an equal amount of anterior chamber inflammation. 'Large cortical fluff nasally into the visual axis', refers to the retained lens material. Dr. Goldfarb questioned if this was the first indication of retained lens material or was it when the lens was dropped during surgery. Dr. Farber explained that what happens during a cataract procedure if there are complications involving in vitreous presentation, the back surface of the crystalline lens opens, tears, or is violated in some way. He explained that it does not necessarily mean the lens material will be permanently retained in the eye. Dr. Farber stated he did not know at the time of the surgery that there was retained lens material; the first indication was during this exam on May 19th.

Dr. Goldfarb asked what was the proper thing to do. Dr. Farber explained that it depends on the patient's progress. Retained lens material can be removed with a second procedure or it can be retained in the eye and allowed to digest. The size of the material does not necessarily have a bearing on which action to take. Dr. Farber explained the complications at this point were increased intraocular pressure and increased inflammation. He felt at this point it was best to watch the situation. Because the intraocular pressure was higher than it had been he chose to change the topical steroid to a less potent steroid at a higher dosage. Less potency means less effectiveness, however, it also prevents the pressure from being raised.

May 21, 1997, the patient returned for a follow-up. Dr. Farber read, 'patient states left eye hurts, eye is tearing and he cannot see'. The intraocular pressure is now 19. '1+straie', '1+flare and cell', which indicated the cornea was coming back to a more normal configuration and the inflammation in the anterior chamber was reduced. That was probably based on the increased dosage of steroids. Dr. Goldfarb stated that this exam was approaching two weeks post-surgery. Dr. Goldfarb asked what the literature says about when retained lens material should be removed to avoid complications in retinal changes. Dr. Farber said it recommends within two weeks, but he felt it should be based on each individual and the patient's progress. Dr. Farber continued reading his notes and indicated the patient was complaining about increased pain so he use changed the medication.

May 28, 1997, the patient returned for a follow-up. Dr. Farber stated that the patient noted increased pain. He checked the cornea and anterior chamber and they looked the same. The cortex, retained lens material looked the same. Dr. Farber had a good enough view of the posterior pull to see that the optic nerve and maculae were normal. He was not sure why the pressure had gone up since the inflammation was subsiding. Dr. Farber stated that he stopped the steroid hoping that would get the pressure to come down. June 11, 1997, the patient returned for a two-week follow-up. Dr. Farber stated the pressure was 20. There was no flare or cell in the anterior chamber. There was a small amount of haze in the vitreous. The optic nerve appeared normal. Dr. Farber felt at this time the patient was getting better. He did not see a problem. There was no evidence of anterior chamber inflammation. Primarily treating the patient's intraocular pressure with a topical.

July 15, 1997, the patient came in for the one month and three day follow-up. Dr. Goldfarb stated at this point it was now past the golden period of two weeks and stated Dr. Farber was now considering doing surgery to prevent irreversible retinal changes. Dr. Goldfarb asked if Dr. Farber if he was past the point of no return. Dr. Farber stated that there really is not a closed or open window of opportunity for a second stage procedure if the patient's course demanded it. Dr. Farber clarified that it would be reasonable at 2 weeks, 2 months, 6 months, or any time during the post-operative period to consider a procedure if the patient's course demanded it. Dr. Goldfarb asked why the literature showed 14 days. Dr. Farber explained that the assumption is if there were significant inflammation, waiting longer would not do the patient good. Dr. Farber read the records, which stated 'patient was seeing a lot of dots', which is the vitreous haze. Dr. Farber notes this was the first time there was a notation on the patient's vision. The vision was 20/40, intraocular pressure was 17, no evidence of anterior chamber inflammation.

Dr. Goldfarb explained the allegation that Dr. Farber failed to evaluate in the post-op period by not doing an adequate vitreous retinal examination, and that the doctor never dilated the pupil enough to actually do a proper fundous examination. The allegation says that none of the notes (that were just reviewed) documented a dilation examination. Dr. Farber agreed with the allegation, he did not document and recognized the failing in doing this. Dr. Farber added that the psychoplegic agent that was used during the patient's pain by nature dilates the pupil. Also, because of the type of intraocular lens the patient had, the patient's pupil was permanently mid-dilated even in its resting state. Dr. Farber agreed that he failed to document any examination of the peripheral fundus. Dr. Goldfarb stated that because Dr. Farber did not dilate the pupil and get a good look at the fundus, he also did not do a depressed peripheral fundoscopic exam to depress the eyeball, or refer the patient to a retinologist so that he could do a depressed examination. Dr. Farber admitted that depression would be useful and even mandatory in a situation where a patient is suspected of having peripheral retinal tear or retinal detachment. It would not be of value in the situation at hand. He felt it was fair to say he documented poorly. Dr. Farber did not feel it was fair to say he did not have an opportunity or capability of examining the retina because part of the patient's pupil was psychopleged and during the entire post-op period his pupil was mid-dilated because of the intraocular lens. Dr. Goldfarb asked what Dr. Farber would do if this was a board exam and he was asked to define the procedure for dropping a lens during surgery. Dr. Farber replied that intra-operatively, there is little recourse other than to do what he had done. If the posterior capsule is violated, that what the operating surgeon has to do is remove all or as much of the cataract as is accessible, remove any vitreous that prolapses anteriorly, then complete the operation.

Dr. Goldfarb stated the patient has permanent injury in his left eye vision and made an accusation that Dr. Farber failed to timely diagnose the retained lens material and act accordingly. Dr. Farber responded that it was a concomitant of surgical complications that the patient lost vision. He felt it is reasonable to say that he did not document as well as he could have. He felt it was probable that there was lens material that he did not see. In retrospect, Dr. Farber stated he would document that he had examined the retina, and either found or not found additional lens material. Postoperatively he does not feel he would have done anything differently in management as long as the patient remained in his care and remained inflammation free with normal intraocular pressure. He stated that he has changed his practice pattern to make sure that he does a dilation examination within two to three weeks after surgery and document it. Dr. Goldfarb stated that the next doctor that served the patient found a three-disc diameter piece of lens in the vitreous and described defuse cystoid macular edema with hemorrhaging. Dr. Farber was not aware of the doctor's findings, but he agreed that those findings were certainly possible.

Mr. Cummings, counsel for Dr. Farber made his closing statement to the Board. He noted that when a physician has been a defendant he has an opportunity to reflect on how he got there and how can he avoid how not to get back there again. He stated that Dr. Farber had done that. Mr. Cummings stated that Dr. Farber not only recognized the need to document better, he also has learned not to rely solely on the natural condition of the pharmacology and the condition of the eye, but to administer a dilation of the eye. This gives Dr. Farber the ability to do an exam that would satisfy him that he has actually seen all of the retained lens material or other complications. Dr. Farber has implemented this now into his practice. After litigation before the Board opened the case, Dr. Farber took 55 credit hours in cataract surgery, which includes postoperative management from American Academy of Ophthalmology. This course included intraocular lens issues. Dr. Farber brought with him the syllabus from his course and 5 random postoperative patient charts to show that he does now do dilation exams. Mr. Cummings stated that Dr. Farber has no prior discipline and wants to do a better job. Mr. Cummings stated to the Board that he felt an Advisory Letter would be appropriate. The Board accepted Dr. Farber's testimony without needing to review the materials supplied to the Board.

MOTION: Robert P. Goldfarb, M.D. moved to find unprofessional conduct for failure to make a timely diagnosis of the retained reference material in the patient's eye.
SECOND: Patrick N. Connell, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

Dr. Goldfarb commented that Dr. Farber had no previous Board actions. He had an unfortunate postoperative complication and was following the patient closely and thought he was covering all bases, but obviously was not. Dr. Farber understands the situation and has changed his practice. The only allegation was that Dr. Farber might not have done a complete examination of the vitreous retinal area.

MOTION: Robert P. Goldfarb, M.D. moved to issue an Advisory Letter for a minor technical violation for A.R.S. 32.1401(26)(q) any conduct or practice that is or may be harmful.
SECOND: Ingrid E. Haas, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D., William R. Martin III, M.D., Douglas D. Lee, M.D., Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Ram R. Krishna, M.D., Lorraine L. Mackstaller, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, Ph.D., R.N. The following board Members were absent: Becky Jordan
11-yay, 0-nay, 1 absent
MOTION PASSED.

6a.	MD-04-0100A	AMB	MARK R. MOURITSEN, M.D.	28909	Draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure, 5 years probation in the Monitor Aftercare Program (MAP). Dr. Mouritsen will be allowed to practice under the monitoring agreement he has established with Dr. Bennett. If the agreement with Dr. Bennett should dissolve another agreement will be reached with Board staff for a period of 2 years to preclude prescribing class 2 narcotics. Credit will be allowed for the time served for not prescribing class 2 drugs under the MAP.
6b	MD-04-0100A	AMB	MARK R. MOURITSEN, M.D.	28909	

Dr. Mackstaller stated she knows Dr. Mouritsen, but it would not impact her ability to adjudicate.

B.B. spoke at the Call to the Public. B.B stated that he got up at 7:00 am and drove 240 miles to attend this meeting because he felt it was important to talk to the Board. B.B described his background to the Board to demonstrate his ability to speak on behalf of the community towards Dr. Mouritsen's character and how Dr. Mouritsen relates to the community in Round Valley, which is in Springer Ville. B.B has been a resident of that community for 24-and-a-half years. In that time B.B had received several accolades: B.B. was teacher of the year, a Varsity Scout Leader of the year, a citizen of the year for the Rotary Club, served two commissions from the town of Eager on Economic Development, and serves currently as a Bishop in the LDS church. B.B. commented that he did not share this information to brag, but to show that he understands his community. B.B. has been has been deeply involved in the community and has a lot of love and respect for it. B.B. then described how he met Dr. Mouritsen. B.B. had two instances in the emergency room where he saw Dr. Mouritsen working. The first instance Dr. Mouritsen worked on a good friend of B.B.'s that fell off a cliff after chasing an elk and had broken some ribs and shattered a leg. The second instance was a couple of weeks later when Dr. Mouritsen was the attending physician in the Emergency Room. Dr. Mouritsen was working on lady who had a seizure in the grocery store. B.B. stated that Dr. Mouritsen was very professional in attending to both situations and did everything that could have been done. Both patients recovered.

B.B. explained that he met Dr. Mouritsen in an ecclesiastical manner about 9 months ago. After one of the LDS church meetings, Dr. Mouritsen asked to meet with B.B. At that time, Dr. Mouritsen was very angry, had a hard chip on his shoulder, and was difficult to talk with. B.B. stated that it was not because of his license situation that he was there. Never at any time had Dr. Mouritsen not admit to screwing up in his Practice in Payson. B.B. worked with Dr. Mouritsen in consultation for several months, and during that time, B.B. saw a man that totally changed his inner self spiritually and mentally as to dealing with people and being an integral part of the community. B.B. stated that Dr. Mouritsen had spent over 220 service hours for the town of Eager this summer. Dr. Mouritsen helped them in their Parks and Recreation department. B.B. stated that the man that he met 9 months ago is not the same man sitting beside him today. B.B. commented that Dr. Mouritsen has passion and consideration for the people around him and that he is as top notch as any of the people he has contact with. B.B. noted that he came to pass this information on to the Board.

Mark R. Mouritsen, M.D. was not represented by counsel.

Cathleen Riggs, Manager of the Office of Investigations, presented the case. On January 26th of 2004, board staff was notified that Dr. Mouritsen had been arrested by the Payson Police Department and had been charged with 17 counts of obtaining narcotic prescriptions by fraud. It was alleged that Dr. Mouritsen may have been impaired and was diverting narcotics for his personal use. It was also alleged that Dr. Mouritsen had prescribed narcotics to patients whom he did not have a doctor-patient relationship. Dr. Mouritsen was noticed on the unprofessional conduct of d., f., g., j., q, and e.. Dr. Mouritsen checked into inpatient drug treatment at Banner Health on February 24, 2004 with a 28-day stay. He was entered into the MAP under an interim consent agreement of May 10, 2004. He has been in full compliance with MAP as of this day. On October 5, 2004 Dr. Mouritsen pled guilty to two class 6 open ended felonies, count one was facilitation to obtain a narcotic drug by fraud and count two was compounding of obtaining narcotic drug by fraud. The investigative report shows definitions of those felonies and how they were handled. Ms. Riggs made a correction to the SIRC report stating that the report shows he had pled guilty to 2 class 6 felonies and one class 3. The class 3 was an error and Dr. Mouritsen did not plead guilty to that. Ms. Riggs stated that the balances of the originally charged counts were dismissed. During the

investigative active interview Dr. Mouritsen admitted to all allegations as noticed. Ms. Riggs noted that Dr. Mouritsen's probation officer, Mark Jernof of Gila County, contacted her and stated that Dr. Mouritsen had been compliant with his probation and court orders for community service and payment of funds.

Dr. Mouritsen made an opening statement. Dr. Mouritsen stated that he takes full responsibility for everything that has happened in the case. He stated that he was very sorry for the embarrassment that it brought to his colleagues in Payson and for the embarrassment he brought to his family. Dr. Mouritsen commented that he had worked very hard to become a physician. He started out as a meat cutter and then became a paramedic for the fire department. Dr. Mouritsen said that he could not read when he graduated High School. He learned how to read when he started as an undergrad. Dr. Mouritsen started school when he was 34 and finished his residency when he was 44 or 45. Dr. Mouritsen stated that he had worked for 3 years as a physician before he messed up. Dr. Mouritsen said he was not proud of what he did, but he has gained some introspect that he otherwise would not have had. In recovery, he was able to settle down and come to grips with his spirituality. He stated that he learned how to get along with others and learned the value of life. Dr. Mouritsen concluded by saying he was terribly embarrassed by the entire incident and is willing to answer any questions the Board has and would do so with honesty and professionalism.

Patrick N. Connell, M.D. led the questioning and stated that Dr. Mouritsen had addressed most of his concerns in his opening statement. Dr. Connell stated that part of recovery process is being able to acknowledge part of the problem. Dr. Connell focused his questions around Dr. Mouritsen's sobriety and relapse strategy. Dr. Mouritsen stated his sobriety date was February 24, 2004. He stated that he has been compliant with all of the Board's requirements and felt it was a good program. It was rigorous and kept him involved on a daily basis as far as attending his 12 step meetings, attending group therapy, seeing the psychiatrist quarterly, doing random calls for the color of the day, doing random court calls, and filling out a medication log. In addition, Dr. Mouritsen stated that he does 8 hours each week of community service. He commented that it helps to remind him why he is there doing the service and helps him understand that what he did was wrong and that he does not want to go back there. Dr. Mouritsen stated the most important thing that has changed is he has become very spiritual. He prays daily, and feels the spirit of his Heavenly Father daily, he teaches Sunday school, and is involved with his church. Dr. Mouritsen feels that MAP, the community service, and his church services keep him busy with his sobriety. His commitment to sobriety is rock hard and has remained that way since rehab.

Dr. Connell noted that the Board has seen a lot of physicians with chemical dependency issues and extended his appreciation for the efforts Dr. Mouritsen is making. Dr. Connell commented that he knew the constraints Dr. Mouritsen was under both judicially and through the monitoring he undergoes with Dr. Greenberg. He explained that this is a lifelong illness and it could be a year from now or 5 years from now before he has a bad day. Dr. Connell asked Dr. Mouritsen to explain his strategy for handling bad days. Dr. Mouritsen shared that he has already had urges like that. When it happens he either calls his sponsor, girlfriend, mom, or friends. He keeps involved with service, which helps him get out of himself. The urges are short term and Dr. Mouritsen felt this strategy worked well for him. Dr. Connell asked Dr. Mouritsen to explain his current practice situation. Dr. Mouritsen explained that he has a turnkey clinic that is ready to start in Springerville. It is located in a strip mall in a high commerce area next to Safeway. He has not seen any patients yet, but it is ready to go.

Ram R. Krishna, M.D. asked Dr. Greenburg what his recommendations were for treatment based on Dr. Mouritsen's participation in the program. Dr. Greenburg commented that Dr. Mouritsen's participation was good. There were a number of difficulties that were presented at the time Dr. Mouritsen went into treatment both with the authorities and the severity of his illness. Before Dr. Mouritsen went back to work on an interim agreement with this agency, Dr. Greenburg made the decision from a clinical basis that on a temporary basis during the interim order, Dr. Mouritsen should not be allowed to prescribe schedule II drugs and he should be in a group practice. Dr. Greenberg stated that Dr. Mouritsen did abide by this. Dr. Greenburg felt that Dr. Mouritsen had no problems with his competency or his practice of medicine other than the addiction related incidents. Dr. Greenberg felt if the Board allowed Dr. Mouritsen to return to work as a family practitioner in Apache County he could work with Dr. Bennett. Dr. Bennett has signed an agreement outlining his plan for monitoring Dr. Mouritsen's prescribing controlled substances, which would include all controlled substances.

Dr. Krishna asked who Dr. Mouritsen's sponsor was. Dr. Mouritsen identified his sponsor and noted he met him at Banner. Dr. Krishna asked about Dr. Mouritsen's health. Dr. Mouritsen stated he takes medication for Asthma and a degenerative hip that needs replacement. Dr. Mouritsen stated that he is seeing a physician, Dr. Mike Ivy, for these problems. Dr. Ivy is a good friend of his that he has known for 25 years from his paramedic days in Payson. Dr. Ivy accepted the role of physician after Dr. Mouritsen was out of rehab and is aware of his history with the Board.

Sharon B. Megdal, Ph.D. clarified that this case was for the felonies. She stated the SIRC report recommended revocation with a 5-year probation? Ms. Cassetta stated the original SIRC recommendation is not correct and that it had been corrected.

Dr. Mouritsen made his closing remarks. He stated that in the last year and a half he learned about himself and how he fits into the world, he learned that he is a good physician and is competent in doing these things. Dr. Mouritsen stated he has suffered a lot from the stuff he has done to himself. Has no home, he lives in strip mall, has no shower, and has a turnkey clinic that he walks through every day and he wants patients. Dr. Mouritsen said his computers are ready and he is ready to go. Dr. Mouritsen explained that he was doing a sole practice and working in an emergency room at the same time. He has no goal to work in two jobs again. It is his intention to do a good job in a family practice setting. He knows the community can use him, he loves the mountains, and his suffering has humbled him and made him low. Dr. Mouritsen asked the Board to have their hearts softened. He stated the restrictions on his license in combination with the 6 felonies have handicapped him from obtaining employment. Dr. Mouritsen noted that he applied at about 30 places. Many of these places wanted to hire him until it gets to the malpractice and the underwriters were unwilling to take him. He expects to pay 45K annually for malpractice insurance. Dr. Mouritsen stated that he would like to salvage his career, he is a good physician and is good for community. He asked the Board to consider being lenient to the restrictions.

Dr. Greenburg stated to the board that the original recommendation to the Board to have the doctor work in a group practice and not prescribe Schedule II drugs during the interim order was conservative. He felt this was the safest way to restrict him and monitor how he did during this time. Dr. Greenberg stated that Dr. Mouritsen worked for a while in an emergency room and the reports from the emergency room and the medical director were that his quality of care was excellent, that he was a good, safe, qualified emergency room doctor, and unfortunately the employment did not continue. Dr. Greenberg stated his current recommendation would be to accept Dr. Bennett's offer to monitor Dr. Mouritsen's prescribing habits in his practice in Apache County. Dr. Bennett is a respected member of the Apache group of physicians and he has known the Dr. Mouritsen for over 10 years. Dr. Bennett believes that Dr. Mouritsen is a good physician, and is impressed with what he sees so far with his recovery. Dr. Greenberg believes with Dr. Bennett's monitoring and practice survey results and with the MAP monitoring the Board could entertain allowing Dr. Mouritsen to return to work under probationary agreement

MOTION: Patrick N. Connell, M.D. moved to find unprofessional conduct under statutes 32.1401.27(d),(f),(g),(j),(q)
SECOND: Ronnie R. Cox, Ph.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED

Patrick N. Connell, M.D. stated that the Board's past practice has been to institute probation using a MAP term for a period of 5 years minimum. Dr. Connell supports that probation. The issues in this case regarding felonies to which the doctor pleaded guilty are quite serious.

MOTION: Patrick N. Connell, M.D. moved for a Draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure, 5 years probation in the Monitor Aftercare Program (MAP). Dr. Mouritsen will be allowed to practice under the monitoring agreement he has established with Dr. Bennett. If the agreement with Dr. Bennett should dissolve another agreement will be reached with Board staff for a period of 2 years to preclude prescribing class 2 narcotics. Credit will be allowed for the time served for not prescribing class 2 drugs under the MAP.
SECOND: Ram R. Krishna, M.D.

Sharon B. Megdal, Ph.D. asked if the certificate of agreement that the two physicians already signed, one part indicating that a group has already been defined, binds the Board. After the Board votes on Dr. Connell's motion it could consider amending the interim order and make changes to the group practice restrictions. Dr. Megdal stated she had two issues with this order; she does not want the Board to be viewed as defining a group agreement, and she does not want this definition to set a precedent for other cases. Ms. Cassetta stated any definition of "group practice" would only be for the purpose of this case. Dr. Megdal stated that she would like the agreement with Dr. Bennett to include a "monitoring of his work patterns."

Dr. Megdal asked Dr. Mouritsen if there is a small hospital in Springerville. Dr. Mouritsen said there was and it does have an emergency room, which is covered by physician's assistants and one M.D. Dr. Megdal said her concern was that demands could increase on Dr. Mouritsen over time and she wanted to make sure he did not get back into the situation of two jobs. Ingrid E. Haas, M.D., suggested inserting a practice restriction for the number of hours that could be worked each week. Dr. Megdal felt that Dr. Mouritsen had the best of intentions, but with demands from patients it is easy to slip back into an 80 or 90-hour workweek. Dr. Greenberg stated that a formal restriction would have negative effects on the doctor and his ability to get reimbursement. Dr. Greenberg stated the diversion committee would catch if the doctor were overloaded. Based on discussions Dr. Megdal was satisfied with the motion.

Dr. Connell stated under paragraph 2, Dr. Bennett's indicated he would monitor medication logs, diagnosis rational for drugs, and check the medical record. Dr. Connell felt this should be adequate. Dr. Greenberg stated he would make sure that is done.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Tim B. Hunter, M.D., William R. Martin III, M.D., Douglas D. Lee, M.D., Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Ram R. Krishna, M.D., Lorraine L. Mackstaller, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, Ph.D., R.N. The following board Members were absent: Becky Jordan
VOTE: 11-yay, 0-nay, 0-abstained/recused,1-absent
MOTION PASSED.

Tim B. Hunter, M.D. stated the order does not take affect for 60 days. Dr. Mouritsen can work today after the Interim Consent agreement was modified and signed.

MOTION: Patrick N. Connell, M.D. moved to allow the interim consent agreement to be modified to parallel the probation agreement just voted on.
SECOND: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-nay, 0-abstained/recused, 1-absent
MOTION PASSED.

Recess for special meeting 3:47
Open Meeting called to order at 4:05

7.	MD-04-0400A	AMB	JOHN V. DOMMISSE, M.D.	22164	Advisory letter for failure to undergo a PACE evaluation within the time frame specified in the Order. This is a minor technical violation.

John V. Dommisse, M.D. was present with legal counsel, Mr. Kraig Marton.

Kathleen Muller, Physician Health Program Manager, presented the case. In November 2003 the Board voted to issue Dr. Dommisse an order for Decree of Censure and Probation. One of the terms of the order required Dr. Dommisse under go a PACE evaluation within 120 days. Dr. Dommisse did not attend the evaluation as ordered. He forwarded the Board a letter from PACE that stated PACE was unable to perform a clinical assessment in his field of metabolic medicine. Board staff informed Dr. Dommisse that he should undergo a PACE evaluation to assess his competence in allopathic medicine. Ms. Muller explained that Dr. Dommisse did not make arrangements for the evaluation and a noncompliance case was opened. Dr. Dommisse continued to communicate with Board staff and stated that he felt he could not be adequately assessed by the PACE program, that he never accepted the findings and fact, conclusions of law and order in the Board's November 23, 2003 Order, and that he has been under going a lengthy process of appealing the Board orders. He felt that he did not have to attend the PACE evaluation when he was in an appeal process. Upon Board staff request, Dr. Dommisse replied to PACE in January of 2005, however he did not send in the required documentation to complete the registration process.

Ms. Muller stated that on May 19, 2005 the Staff Investigational Review Committee (SIRC) reviewed this case and recommended a 6-month suspension during which time Dr. Dommisse must comply with the Board order to undergo the PACE evaluation. Subsequently, in June 2005 Dr. Dommisse notified Board staff that his request for a stay of the PACE evaluation was denied and that he reapplied to PACE and should complete phase one of PACE in early July. Dr. Dommisse forwarded the Board an interim report from PACE with regard to phase one of the PACE evaluation. Ms. Muller stated that she contacted PACE last Monday and was informed that not all of the results of phase 1 of the evaluation have been received and they do not have a final report right now or any recommendations.

Sharon B. Megdal, Ph.D. began the questioning by asking Dr. Dommisse if he accepted the Board's authority. Dr. Dommisse replied that he did. Dr. Dommisse also confirmed his understanding of the intention of the PACE evaluation to estimate his abilities as an allopathic doctor. He added also that he designates his practice area as nutritional medicine. Dr. Dommisse stated that he is aware of the Board's rule that states any reviewing physician must have a working knowledge of the physician's practice area and he felt this had never been provided to him. Dr. Megdal stated that today's purpose is to deal with the issue of Dr. Dommisse's willingness to comply and PACE's ability to evaluate him. Dr. Megdal asked for clarification on the Phase I PACE Assessment. Dr. Dommisse verified that they are not waiting on material for him to submit. PACE was waiting on results from the computerized exam that was sent to the National Board of Medical Examiners.

Dr. Megdal asked if it was Dr. Dommisse's intention to submit to phase two of the PACE evaluation if it is recommended. He replied that he would. Dr. Megdal stated she needed to get this on the record because the Board does not have a history of Dr. Dommisse's willingness to do the PACE evaluation until recently and it is important to determine if there has been a violation of the order and the probationary terms. Dr. Megdal went through the timeline of events with Dr. Dommisse. On November 20, 2003 the Order went into effect. Based on the 120-day duration to complete the evaluation it should have been completed by March 20, 2004. The appeal was filed December 30, 2003. In the initial filing along with the complaint as part of the relief asked for a stay of the penalties imposed. On March 29, 2004 a compliance case was opened and on May 2, 2005 a ruling was made for a stay on the fees, but not for a stay on the PACE evaluation.

Dr. Megdal asked Christine Cassetta if the Order was in effect during the time when the appeal was filed until the stay was granted. Ms. Cassetta stated that because the court did not grant the stay within the 35 day time period the order did take effect.

Dr. Dommisse made closing remarks. He did not, at any time, intend to defy the Board's order of November 23rd that he take the PACE evaluation. Before the time period was up, Dr. Dommisse had received the letter from the director of the PACE program that they could not evaluate him. This was mentioned in every quarterly report. It was not until December 23rd of 2004 that the compliance officer wrote a letter stating he was out of compliance with doing a PACE evaluation in a general allopathic practice which was not in the doctor's area of practice. Dr. Dommisse addressed the issue immediately upon his returned from his vacation in South Africa in January. He paid the deposit and applied for the program. Dr. Dommisse stated there was also a delay because a judge had not been assigned to the stay that went to the Supreme Court until early 2005. The judge turned down the stay in early May. Dr. Dommisse asked for reconsideration, but it was denied in June. At that point, he immediately went ahead and collected the required documents and sent them to PACE. He completed the Phase I of the program by July 6, 2005.

Mr. Marton made his closing remarks. He stated that this was an unusual situation where a doctor chose to exercise his rights to appeal to the Board's order. For various reasons it took along time for the matter to be decided from the day they filed to the day the stay was denied. Dr. Dommisse then immediately completed his PACE evaluation. There was no intent to violate the Board's order. Mr. Marton did not believe that the doctor ever violated his Board's order. Dr. Dommisse has sent in his quarterly reports. He was late on one, for which Mr. Martin took responsibility. Dr. Dommisse has continued education as required by the Board and has been fully compliant with everything required of him. The Board dropped the ball because he told the Board in his quarterly reports that PACE could not evaluate him on nutritional medicine and for nine months the Board did nothing about it. He was evaluated as an allopathic practitioner and received 9 out of 10 marks. He was told this was one of the highest scores they had seen and hope that this matter will be dismissed.

Ms. Muller stated that Dr. Dommisse was notified March 31, 2004 stating clearly that he should undergo a PACE evaluation to assess his competence in allopathic medicine, which is evaluated wholly within PACE's expertise. From the beginning he was made aware of

what type of evaluation to go with. Mr. Marton replied that he did receive the letter and eight days later he replied back that PACE could not do it and asked for assistance. He has proof that the letter was sent.

Dr. Megdal felt this was an unusual case. Before receiving the supplemental information she had only one question on what steps were taken since the May decision to undergo PACE. Dr. Dommisse has taken steps to do that. There is however a minor technical violation of the order as stated by Ms. Cassetta and Mr. Marton agrees the Order was effective.

MOTION: Sharon B. Megdal, Ph.D. moved to issue an advisory letter for failure to undergo a PACE evaluation within the time frame specified in the Order. This is a minor technical violation in light of the legal circumstances surrounding this case.
SECOND: Patrick N. Connell, M.D.

Robert P. Goldfarb, M.D. asked Dean Brekke, Assistant Attorney General, to give his thoughts on the matter. Mr. Brekke said that he agreed with Mr. Martin that this has been an unusual case. There has been an unusual amount of litigation getting the appeal to superior court. Mr. Brekke felt strongly that Dr. Dommisse has complied with every portion of the Board's order that was made in November 2003 except for the PACE evaluation. He took care of his website and did all the other things the Board asked him to do. If he did not feel the Board order was in effect he probably would not have complied with rest of it. If there was some confusion of the exact nature of what needed to be done. Inquiries could have been made much sooner than they were.

Robert P. Goldfarb, M.D. stated the one portion that Dr. Dommisse did not comply with is having paid expenses and that is still being litigated. There is a court order that says he does not have to pay that right now, but that could be changed by the judge. Mr. Brekke said payment of fees could be stayed because the payment of the administration costs does not affect the public safety whereas competency of the physician does.

Dr. Megdal concluded that violation of Board orders are taken seriously and the Board normally issues nothing less than a Letter of Reprimand. Because of communication glitches with the quarterly reports and because of the speed in which the doctor subjected himself to PACE evaluations after the stay was denied, Dr. Megdal did not find that the physician committed unprofessional conduct.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, M.D., Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Lorraine L. Mackstaller, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, Ph.D., R.N.
The following board Members were absent: Honorable Becky Jordan
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

8.	MD-03-0666A	A.B.	MARK ZACHARY, M.D.	12879	Dismissed.

William R. Martin III, M.D., stated he knows Mark Zachary, M.D. and recused himself from the case. Patrick N. Connell, M.D. knows Mark Zachary, M.D. and stated that it would not influence his ability to adjudicate this case.

Dr. Zachary was present with his legal counsel, Mr. Winn Sammons.

William Wolf, M.D., Board Medical Consultant, presented the case. This case came to the Arizona Medical Board on July 17, 2003 as the result of a complaint by A.B. It was alleged that Dr. Zachary deviated from the standard of care by negligently performing a right hip replacement that resulted in reflex sympathetic dystrophy. An outside medical consultant opined that A.B. did not have a neurological problem prior to the surgery and the loss of nerve function she described postoperatively was due to the surgery. There were no aggravating or mitigating factors.

Dr. Zachary addressed his concerns to the Board in the opening statement. The allegation was that there was an incomplete neurological evaluation. In Dr. Zachary's initial history and physical it mentioned the patient was having difficulty flexing her foot and toes, and post-operatively it mentioned that there was a weakness of dorsiflexion and numbness, so a neurological evaluation had been performed before and after surgery. Initial evaluation did not mention possibility of sensory lost but it was recorded in his post-operative notes.

Ram R. Krishna, M.D. started the questioning with the initial history. Dr. Zachary confirmed that the patient's history showed she had back surgery within the past 5 years. He was aware, prior to her hip surgery, that she had the back surgery. In the initial history he reported that she had periodic pain in her lower extremities. Dr. Zachary did not feel she had any deficit as far as weakness in dorsiflexion prior to hip surgery. Dr. Krishna asked about neurological compromise. Dr. Zachary stated that he recorded in her history that she was having difficulty moving anything on her lower extremity. He said it could have been from the fracture, so he asked A.B. to move her ankle and toes and felt the main problem she was having was with the dorsiflexion of her toes. Dr. Zachary had a difficult time assessing if the problem was related to the fracture because she didn't want to move the ankle. He did not feel there was a sensory deficit prior to surgery. Dr. Krishna asked if Dr. Zachary was able to see the sciatic nerve during the procedure. Dr. Zachary replied that he does not routinely expose the sciatic nerve but instead utilizes the anterior approach.

Dr. Krishna asked about the postoperative process. Dr. Zachary said that it is his standard to have his nurse, of 25 years, place an abduction pillow below the knees and strap it. Dr. Zachary stated that he normally goes into the recovery room and checks the abduction pillow and other postoperative items. The next day Dr. Zachary takes the abduction pillow off and has the patient sit up in a chair. Dr. Krishna summarized that if there was pressure for any period of time that it was short lived and Dr. Zachary agreed. Dr. Krishna asked if Dr. Zachary had ever had an incident of peroneal nerve contusion. Dr. Zachary said that he had and that it usually takes up to 8 weeks to recover. Dr. Zachary mentioned the difficulty with dorsiflexion for A.B. and requested that she be fitted with a

posterior leave brace to help get function back. Dr. Zachary was concerned before and after the surgery because of what he had read on patients having nerve injuries with a history of back problems. Dr. Zachary felt a neurology evaluation would be appropriate. He often consults with a neurologist when putting a patient in a brace that has this condition. Normally the neurologist tells him to wait for the evaluation because the initial EMG evaluation is not very helpful.

Dr. Krishna questioned Dr. Zachary about the discharge. Dr. Zachary stated that she was sent to the rehabilitation center. A.B.'s internists' family doctor was with her and said he would contact Dr. Zachary if there were any orthopedic problems. Dr. Krishna asked when Dr. Zachary was notified of the RSD. Dr. Zachary found out about it when he reviewed the records from the neurologist that the Medical Board sent as part of the investigation. Dr. Zachary had only seen the patient twice after the surgery because she elected to see her own neurologist. On a follow-up visit with A.B. she notified him that she was not using the brace because it bothered her. She was having some pain but Dr. Zachary felt it was too early to make a diagnosis of RSD. Dr. Krishna asked in retrospect where did Dr. Zachary feel the problem with foot drop occurred. Dr. Zachary felt it had occurred during surgery and is not positive if the problem could have been totally avoided. Dr. Zachary described the process that was written in the literature on a similar injury, which explained that during the implant process the nerve does have tension applied to it. He felt this could have happened in the procedure. Dr. Zachary felt everything had been done appropriately though. Dr. Krishna asked if the patient was in traction when she came to him and he said that she came directly from emergency room to the operating room.

Mr. Sammons made a closing statement. He felt the investigator's conclusion was drawn because neurological complications followed the surgery so therefore something must have gone wrong in surgery. There was an indication that Dr. Zachary did an inadequate neurological evaluation after surgery. Mr. Sammons felt that the investigator might not have seen the handwritten notes by Dr. Zachary that set forth rules of neurological examination. There was a concern about Dr. Zachary not having adequately treated the neurological condition and there was a note in which Dr. Zachary clearly referred the patient for neurological consultation through the primary care physician. Mr. Sammons could not find any evidence to support the allegations and did not feel there was any type of conduct that would justify an action by the board other than dismissing the complaint.

Dr. Wolf stated that he could not find evidence of a dictated emergency room record.

Dr. Krishna felt after reviewing the record and through the interview that everything was handled properly. It is an expected complication that could have happened before, during, or after the surgery.

MOTION: Ram R. Krishna, M.D. moved to dismiss the case.
SECOND: Patrick N. Connell, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Ronnie R. Cox, Ph.D., Robert P. Goldfarb, M.D., Ingrid E. Haas, M.D., Tim B. Hunter, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine L. Mackstaller, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, Ph.D., R.N. The following Board Member recused from this matter: William R. Martin, III, M.D. The following board Members were absent: Becky Jordan
VOTE: 10-yay, 0-nay, 01-abstain/recuse, 01-absent
MOTION PASSED.

Prior to adjourning the meeting it was announced that Ingrid E. Haas, M.D. would be leaving the Board after this meeting. Tim B. Hunter, M.D. expressed how saddened the Board was at her leaving and thanked Dr. Haas for her wonderful service. The Board members agreed and wished her luck.

The meeting adjourned 5:18 p.m.

[Seal]

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Timothy C. Miller, J.D., Executive Director